How Montana Physicians View Access to Health Care

Montana Health Education Center
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PREFACE

In August of 1990, Representative John Cobb (a Montana legislator from Augusta) contacted the Montana AHEC to ask assistance in obtaining information about health insurance for the uninsured and underinsured in Montana. Specifically, Representative Cobb asked about our interest in conducting a survey which would include the following questions: (1) Who are the uninsured and underinsured? (2) How do the uninsured and underinsured impact an organization (business, health provider facility, physician clinic, etc.)? (3) What recommendations do organizations and individuals have for increasing health insurance for the uninsured and underinsured? (4) What is the general perception of health care in Montana? and (5) Which programs are working and what changes might be made to improve the delivery of health care in Montana?

In an attempt to respond to the request of Representative Cobb and other members of a legislative committee studying health insurance issues, the Montana AHEC conducted three surveys entitled: (1) Reader Survey on Uninsured/Underinsured in Montana, (2) How Montana Physicians View Access to Health Care, and (3) Survey of Montana Hospital Administrators on Uninsured/Underinsured.

The issues surrounding the lack of adequate health insurance for many citizens in Montana is a problem being addressed by legislators throughout the United States. Access to information about health insurance for citizens living in rural areas is apparently more difficult to obtain. In a 1989 Health Services Research publication, researchers and policymakers suggested the need for more information on the poor and uninsured in rural areas in the following broad categories: (1) breadth and depth of insurance coverage, (2) the extent of uncompensated care provided by physicians and hospitals, (3) adequate medicaid coverage, (4) health care for the homeless, and (5) availability of health care for low-income minorities. The problems of rural access are of particular importance to Montana, since it is defined as both a rural and a frontier state.

National statistics show that about 37 million citizens in the United States do not have adequate health insurance. It has been estimated that 141,000 Montanans are uninsured or underinsured. One of the goals of Governor Stephens' health initiative is to expand coverage to the working uninsured. The Governor's plan, and subsequent legislation, has several provisions which hopefully will improve health care for low-income Montanans and in general have a favorable impact on access to essential medical services.

The response of Montana physicians to this survey is an indication of the great concern which they have for the many issues involved in providing access to health care for all Montanans.

HOW MONTANA PHYSICIANS VIEW ACCESS TO HEALTH CARE

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INTRODUCTION

In response to a request by a group of Montana legislators who were studying issues related to access to healthcare, the Montana Area Health Education Center (MT AHEC) undertook a survey of all physicians in Montana in November 1990. The survey was developed to obtain 1) a better definition of populations without access to care, 2) determine what affects inability to pay has had on both patients and physicians, and 3) determine what solutions physicians think are most appropriate for solving Montana's access problems.

METHODS

In November of 1990, the survey instrument was developed and mailed to 1457 physicians listed in the 1990-91 Montana Medical Association (MMA) Directory. The mailing list included 1234 actively-practicing Montana physicians and 223 retired physicians who are living in Montana. A postage-paid return envelope was included with the survey. Five hundred and nineteen surveys were completed and returned, resulting in a 36% response rate. An additional 5 questionnaires were returned uncompleted, most of these included comments that the physician was no longer practicing medicine.

The questionnaire instrument consisted of 12 multitype questions: 3 multiple choice demographic questions, 5 Likert-type rating questions, and 3 short answer questions. A copy of the questionnaire is included in Appendix I.

Survey responses were entered into a database using dBASE III Plus. Raw data, frequency, percentage, cumulative frequency and cumulative percent were calculated using SAS. Calculations were based on the number of responses to that particular question, and inappropriate responses were ignored. Raw data including frequencies and percentages are included in Appendix II.

RESULTS

Demographics

The survey respondent population was compared to the total population of physicians listed in the Montana Medical Association Directory for community size, specialty, and activity. Figure 1 (Question 1) shows the percent of survey respondents and MMA physicians practicing in different population-sized communities. The greatest percent of respondents (43%) were from communities with greater than 50,000 people. This is slightly higher than the total population of Montana physicians (32.1%) who reside in the two Montana communities over 50,000--Billings and Great Falls.

Physician specialty of respondents (Figure 2, Question 2) were very representative of the total physician population of Montana. Thirty-four percent were in the "Other Specialists" category, while 29% of survey respondents classified themselves as "Family/General Practice" physicians, compared to 23% family practice of the MMA physicians. Other specialties closely resembled the MMA population.

Geographically, the survey sample closely resembled physician populations in the major population areas of the state (Figure 3, Question 3). The greatest number of physicians responding were from Billings (18%), Missoula (17%) and Great Falls (11%) which closely corresponds to the MMA population.

Figure 4 (Question 4) shows that 91.3% of respondents were actively practicing medicine. Close to 7% of survey respondents were retired as compared to 15.3% in the MMA retired category. The lower percentage of retired physicians responding to the survey is quite understandable, especially with the number of surveys that were returned with comments that they were no longer in practice.

PRIORITY GROUPS

Infants and children were given the highest priority ratings for federal and state assistance programs (75 and 70%, respectively) by physician respondents (Figure 5). Pregnant woman and the working poor were the two other groups rated as "high" priority for assistance programs by over 50% of the respondents. The greatest percent of "low" priority ratings were given to workers of industries such as lumber and agricultural (48%), the self-employed (49%), and small business employees (41%). Several physicians commented about the difficulty of prioritizing the groups based on a single characteristic. One physician commented that "people who are trying to help themselves deserve more help than those who don't. Age, minority status, citizen status, and occupation are not relevant at all in this question."

FIGURE 1

Q1. COMMUNITY SIZE OF PRACTICE

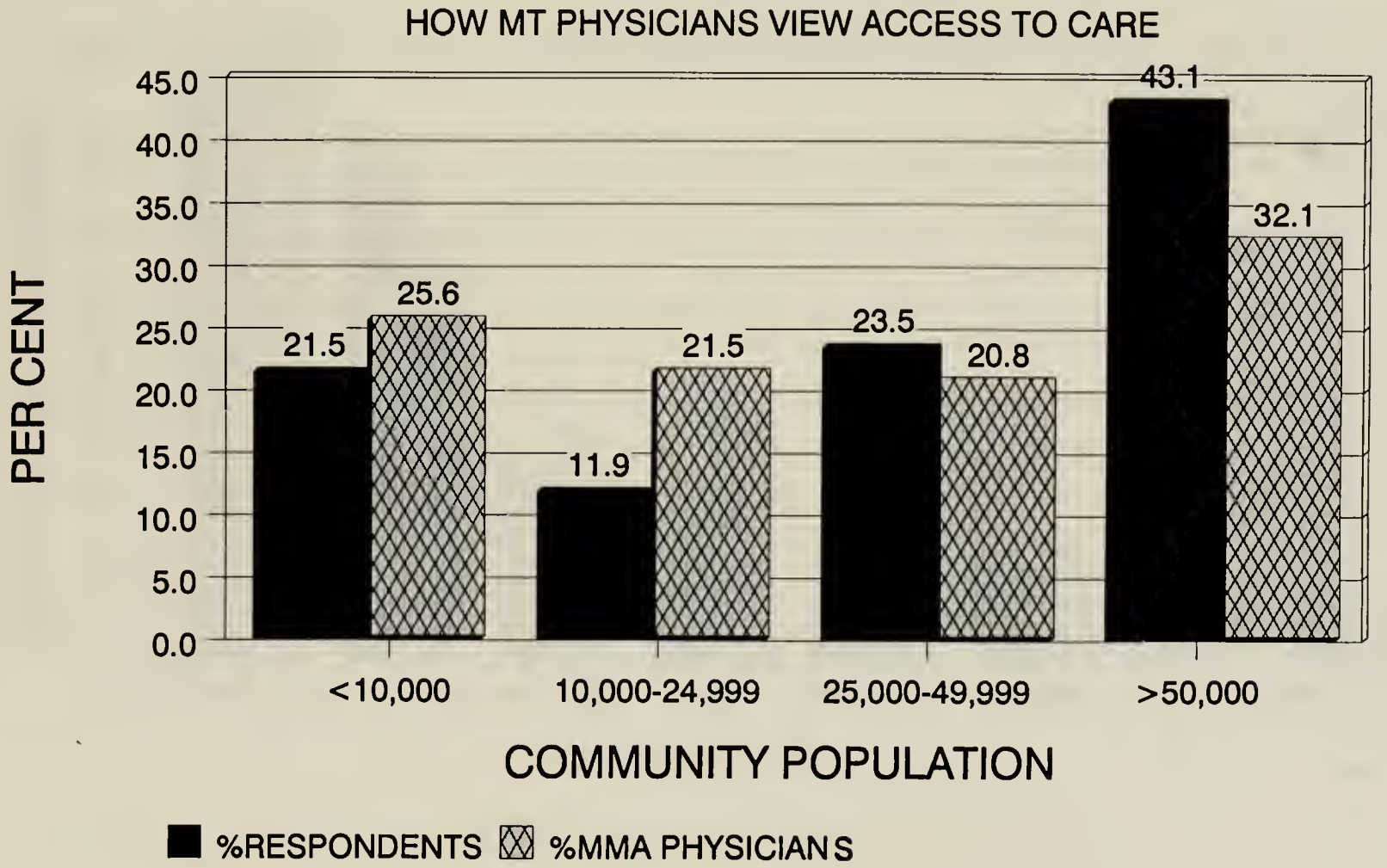


FIGURE 2

Q2. PHYSICIAN SPECIALTY

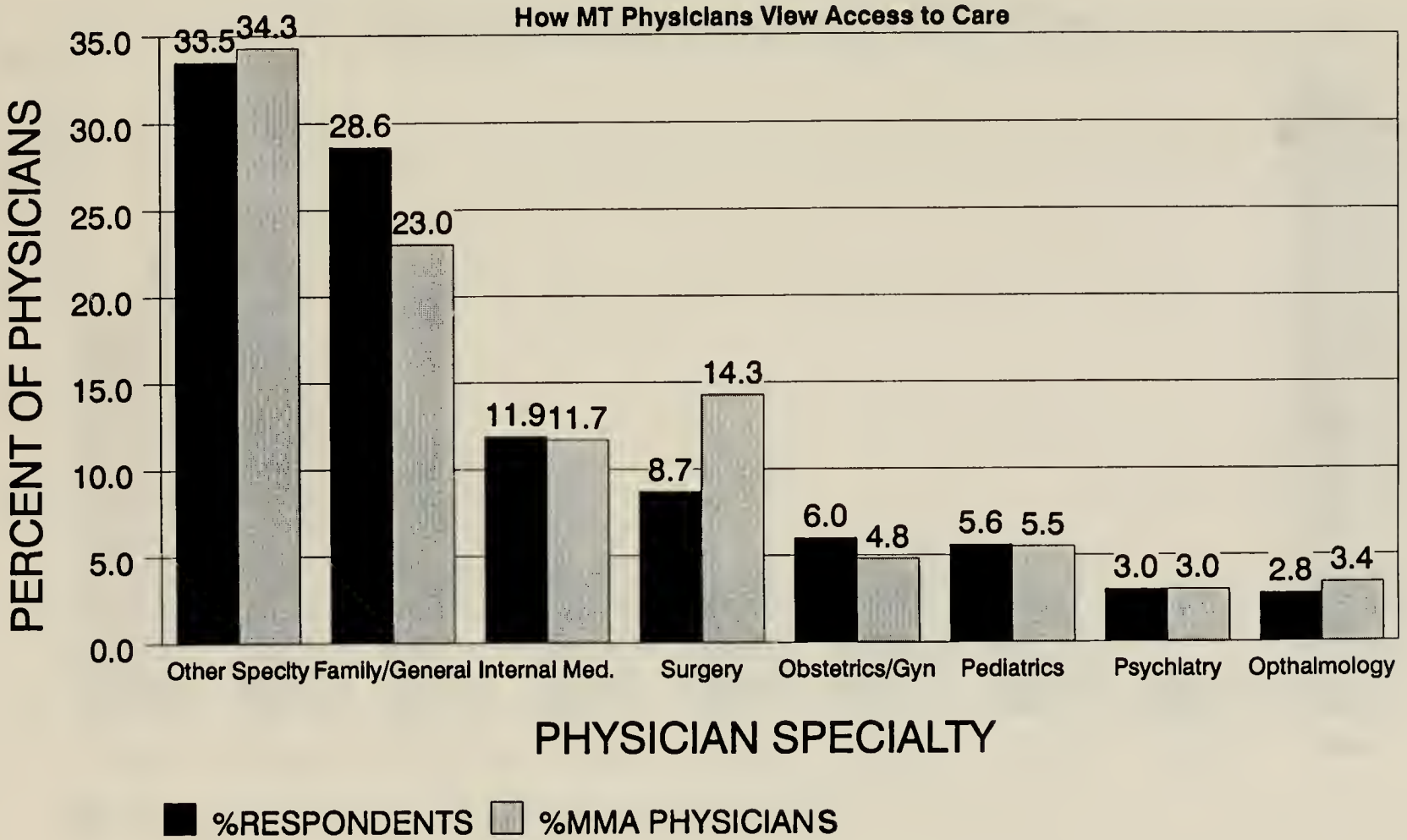


FIGURE 3

Q.3 PHYSICIAN LOCATION

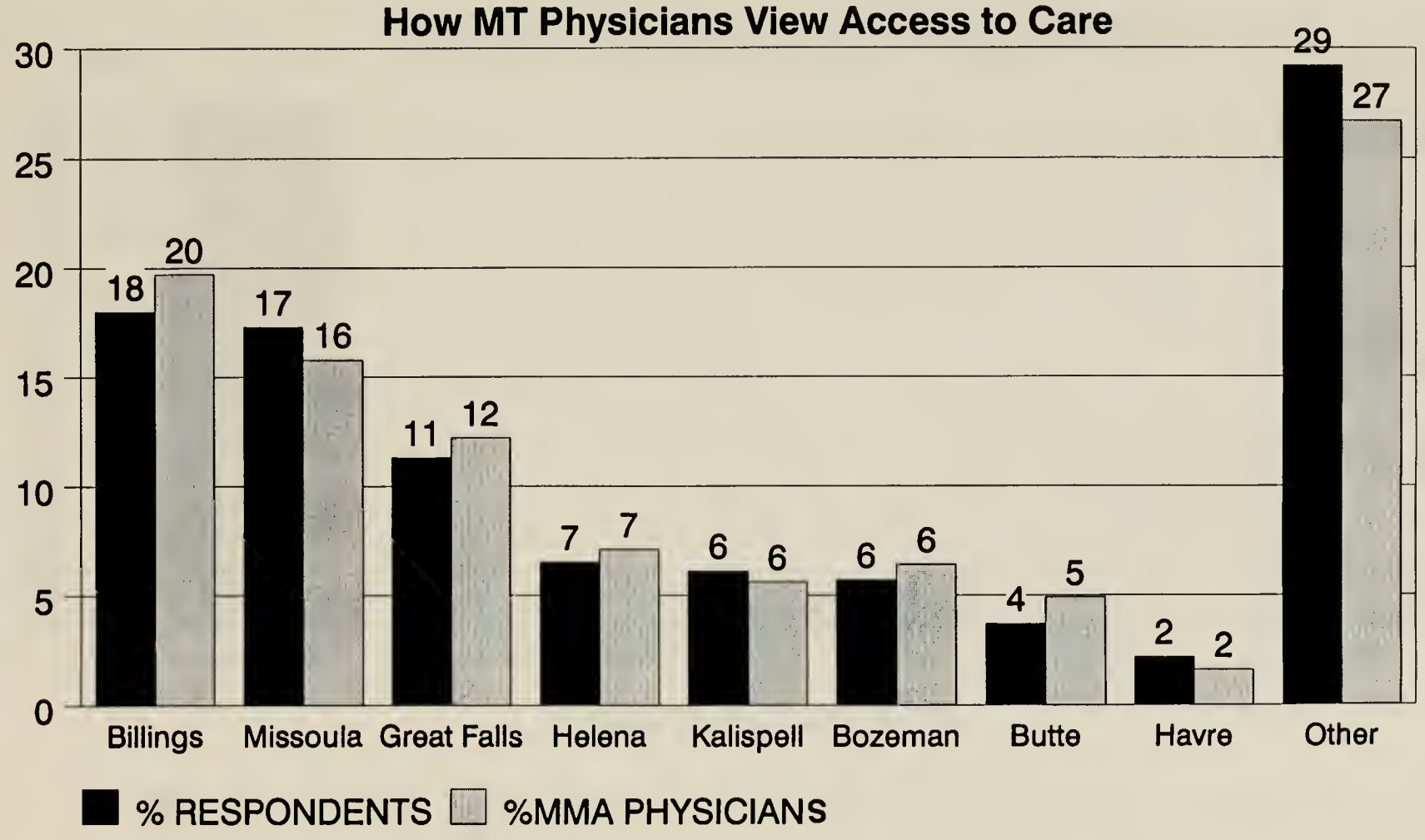


FIGURE 4

Q.4 PRACTICE ACTIVITY

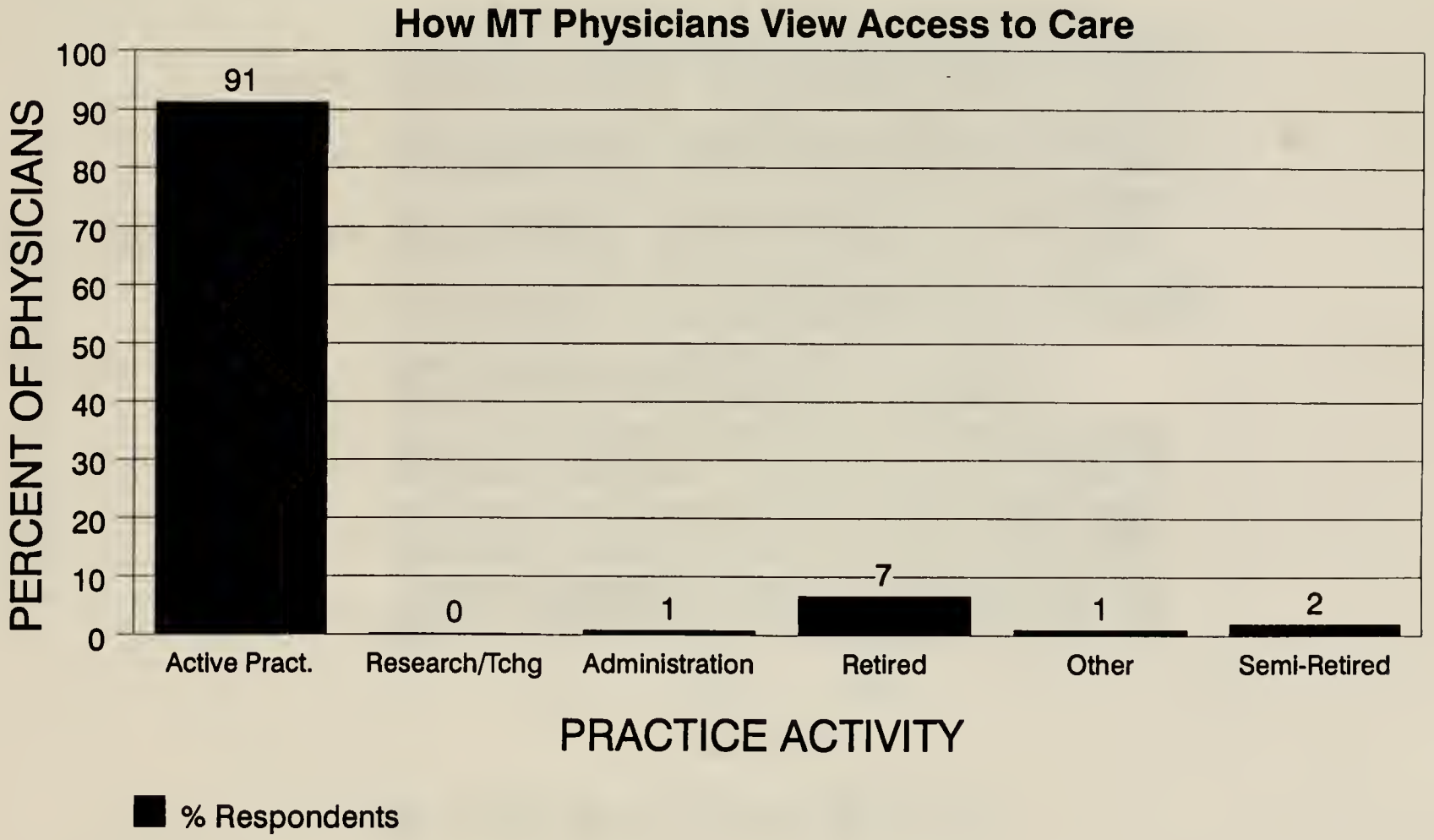


FIGURE 5

Q5. PRIORITY FOR ASSISTANCE PROGRAMS

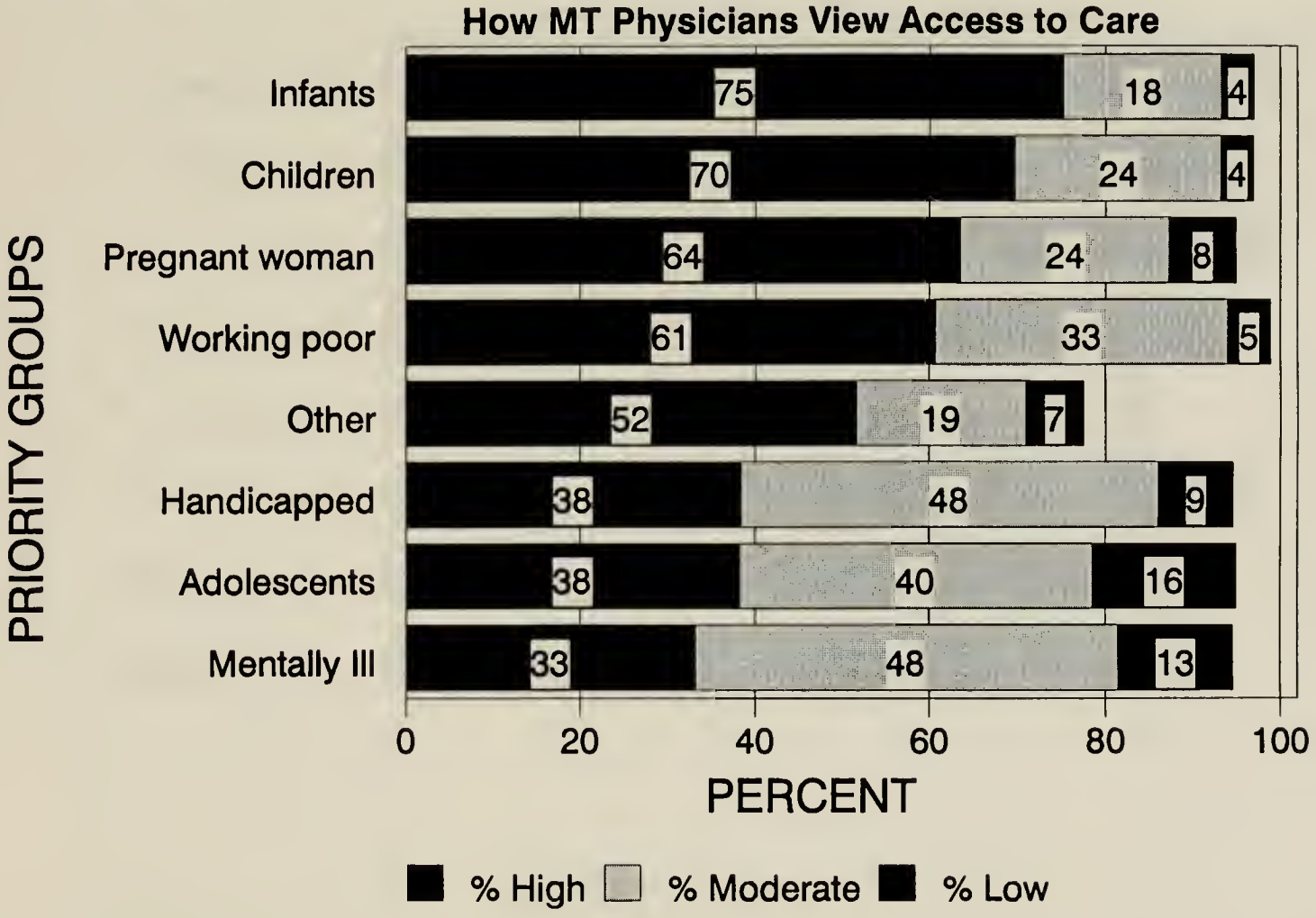
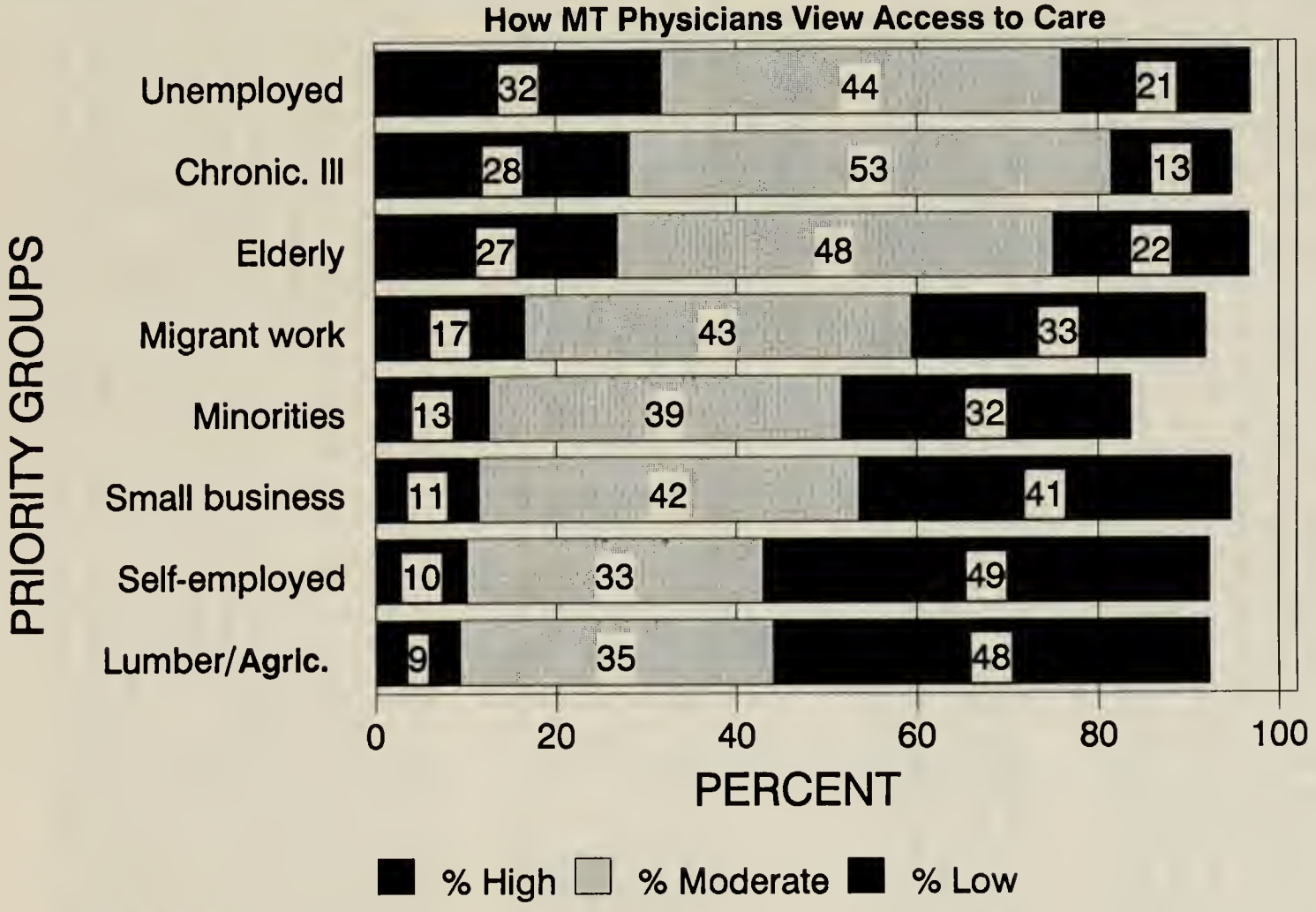


FIGURE 5 (CONT.)

Q5. PRIORITY FOR ASSISTANCE PRGRMS(CONT)



UNCOMPENSATED CARE

Mean values were calculated for the percentage of gross practice incomes reported by physicians (Note: responses did not always total 100%). Physicians reported that 34.7% of their gross practice incomes were derived from private insurance companies, 28.5% Medicare payments, 16.4% from private parties, 14.7% Medicaid, 10.7% Billed for, but not collected, and 9.3% Provided as "Charity Care" (Figure 6, Question 6). These figures indicate that about 20% of a physician's gross practice income is uncompensated--either not billed for or remains uncollected. This figure does not take into consideration the amount which is not reimbursed by Medicaid and Medicare payments. In 1990, Montana Medicaid rates for a physician were approximately 50% of usual and customary charges. Medicare reimbursement is also generally reimbursed below usual and customery charges.

Figure 7 illustrates the variation in income sources for Montana physicians. Each income source is categorized by the percent levels of gross practice income: 1-10%, 11-25%, 26-50% and 50%. The percent of physicians deriving ten percent or less of their income from Medicare was 20% while nine percent of the physicians indicated that Medicare made up over 50% of their gross practice income.

RESULTS OF INABILITY TO PAY

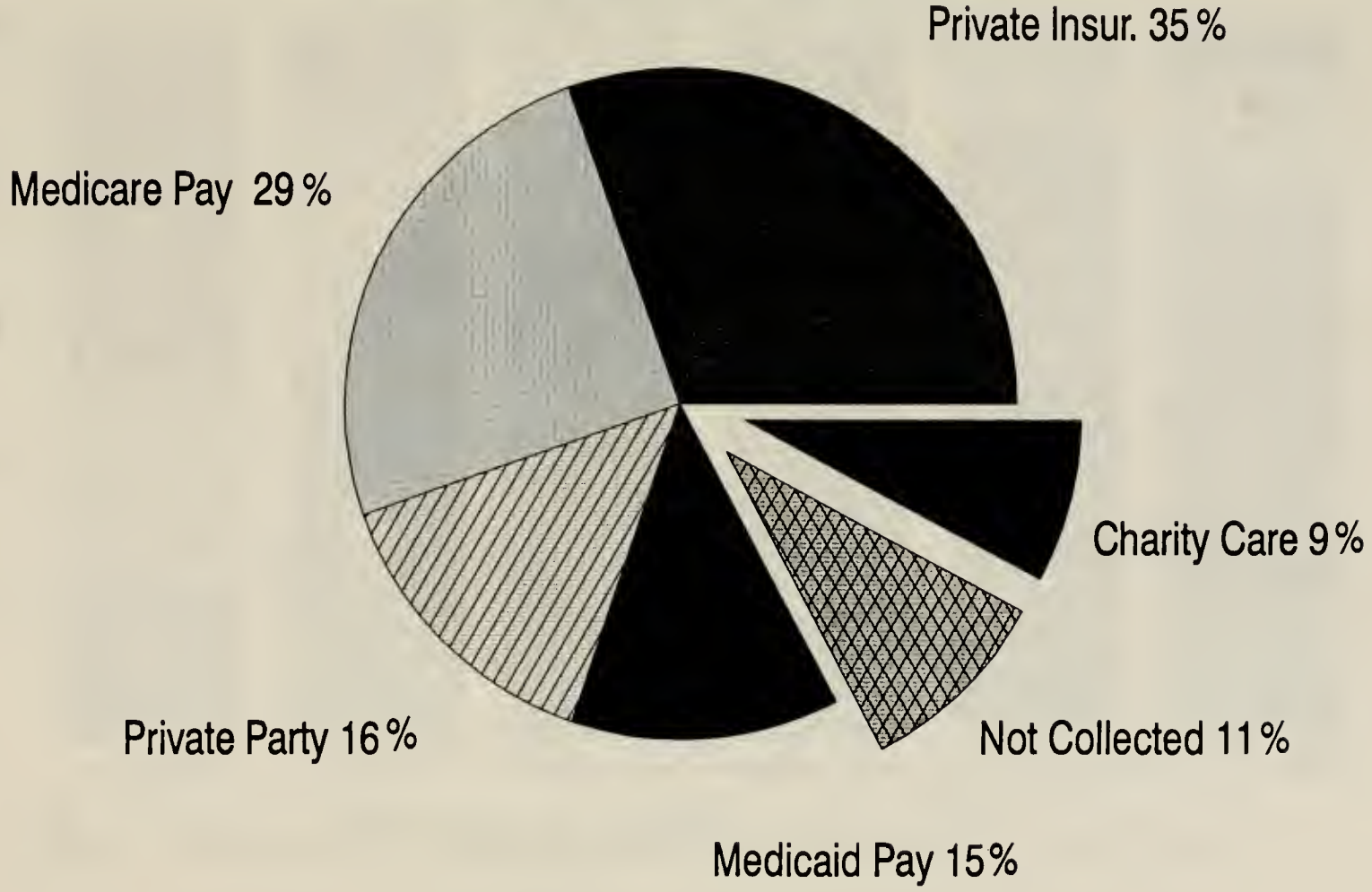
Figure 8 (Question 7) shows how physicians perceive the effect on patients due to inability to pay. A third of the physicians felt patients, because of inability to pay, frequently did not schedule needed follow-up visits. Physicians also felt that because of inability to pay, patients frequently did not follow prescribed therapy (28% of physicians) or delayed getting treatment (26% of physicians). Delaying visits was thought by 18% of the physicians to result in more expensive care. Forty percent felt, however, that inability to pay, did not cause patients to adopt more healthy lifestyles.

Physician's reactions to patient's inability to pay is indicated in Figure 9 (Question 8). About a third of the physicians reported that they frequently ordered different, less expensive medication and 21% of the physicians ordered fewer lab/x-ray tests for patients unable to pay. The survey did not investigate whether the different medication would have a lesser therapeutic effect or if fewer lab/x-ray tests actually resulted in less accurate diagnoses. Seventeen percent of physicians frequently refer patients to agencies providing services such as the local health department or family planning program. Only 2% of the physicians said that they would frequently not see patients for non-emergency cases while less than 2% indicated that they would spend less time with patients because of inability to pay. Over 90% of the physicians said that they would never treat patients in a less sympathetic manner and almost 12% indicated that

FIGURE 6

Q6. PERCENTAGE OF GROSS PRACTICE INCOME

How MT Physicians View Access to Care



Mean Values Utilized So Do Not Equal 100

FIGURE 7

Q6. PERCENT OF GROSS PRACTICE

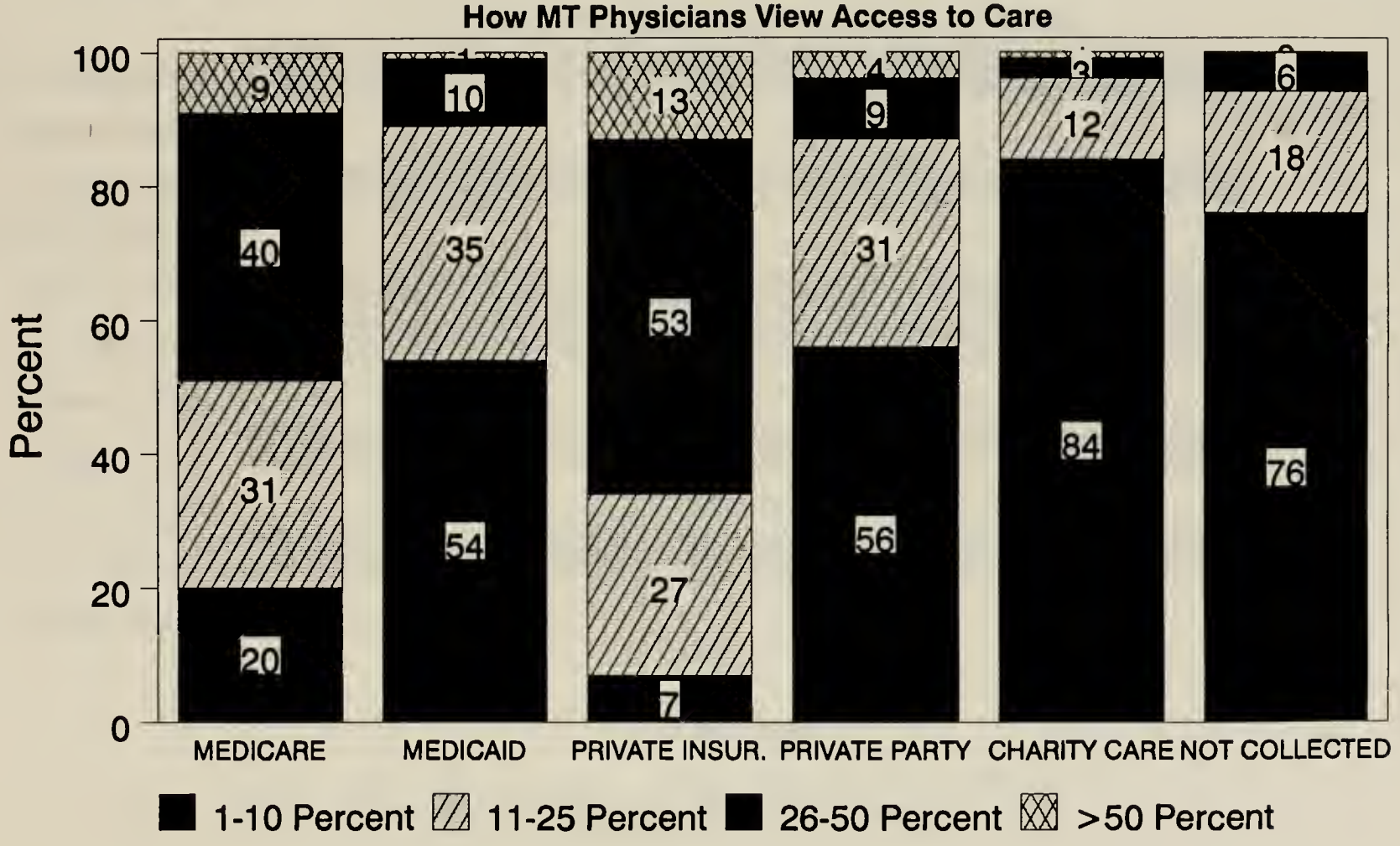


FIGURE 8

Q7 BECAUSE OF INABILITY TO PAY, PATIENTS

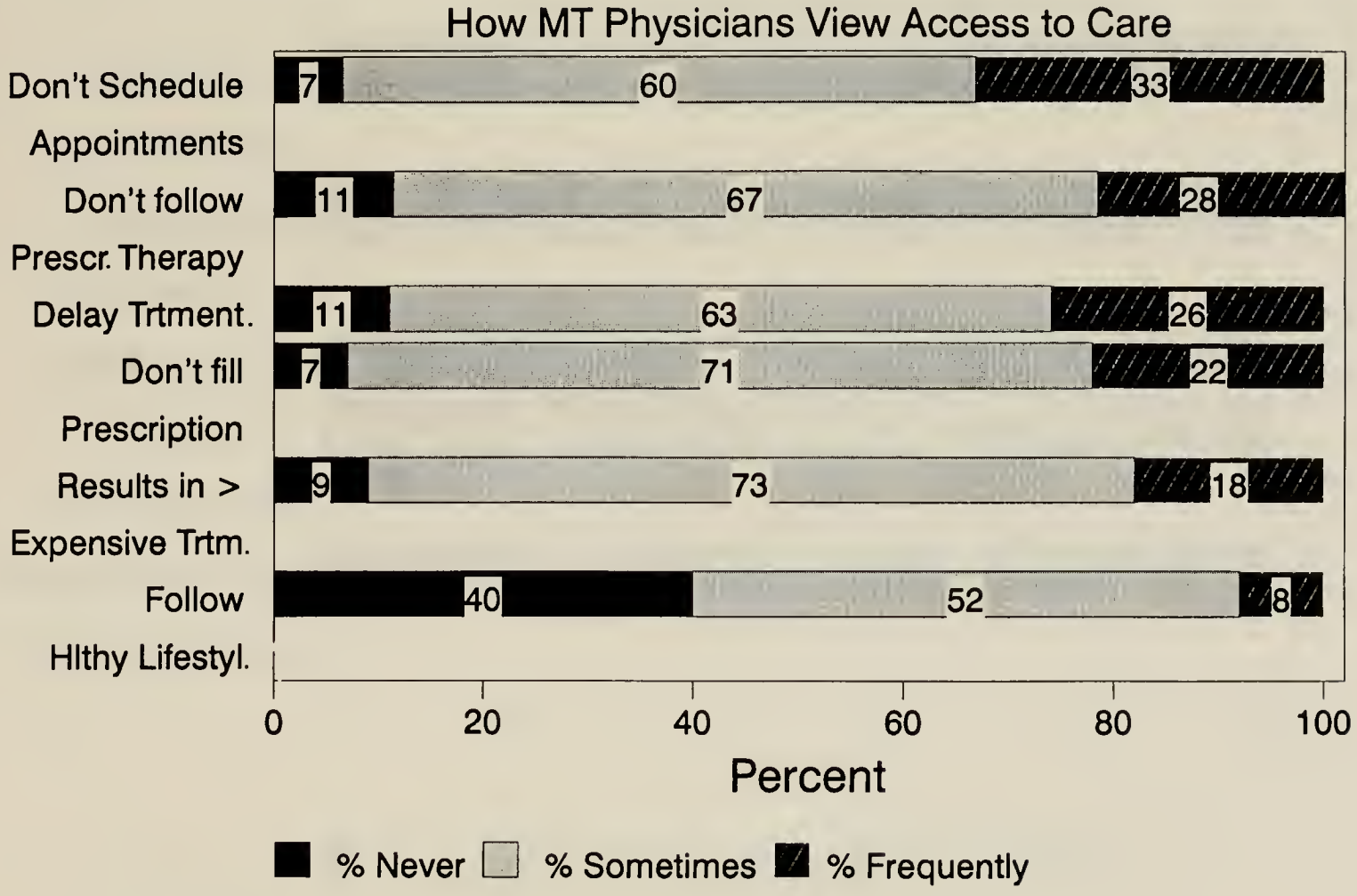


FIGURE 9

Q8 IF PT IS UNABLE TO PAY, HOW OFTEN DO YOU

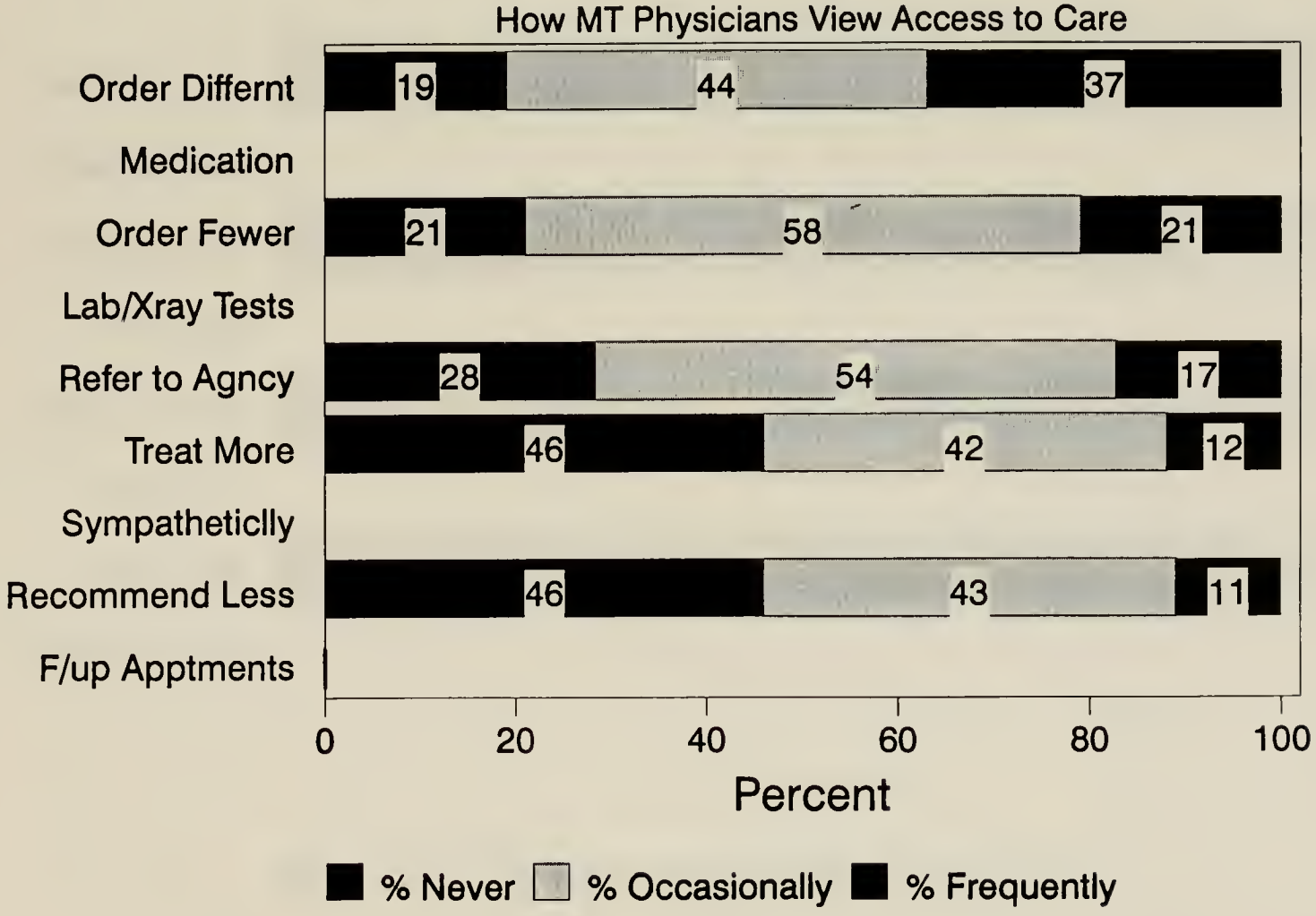
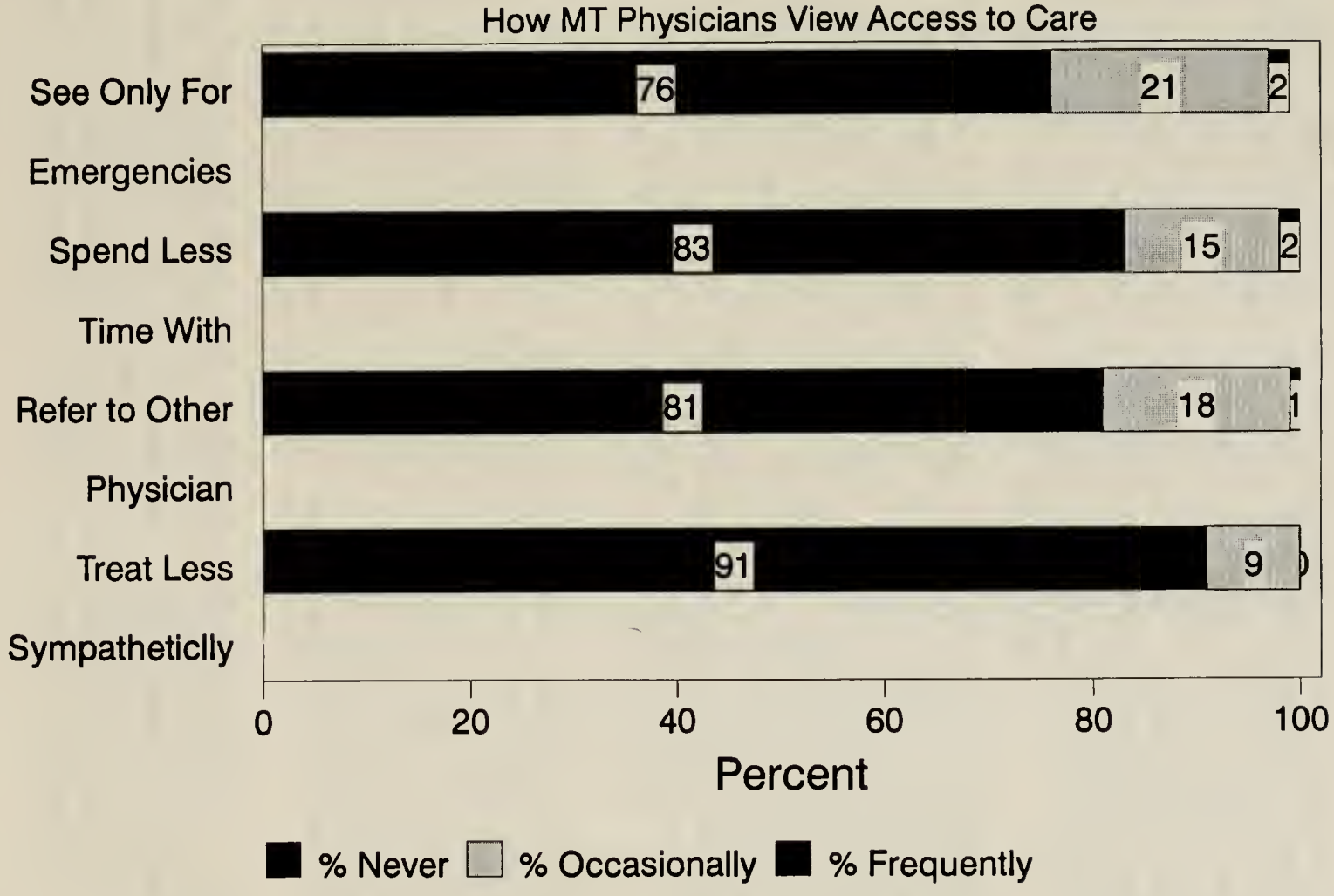


FIGURE 9 (Cont.)

Q8 IF PT IS UNABLE TO PAY, HOW OFTEN DO YOU



they frequently would treat patients in a more sympathetic manner because of inability to pay.

SOLUTIONS

Figure 10 (Question 10) shows the mean values for how the physicians rated strategies for addressing the uninsured/ underinsured problem on a scale of 1 (most desirable for Montana) to 7 (least desirable). "Incentives for employer-based health insurance coverage" (2.2 mean value), "Offer more affordable 'basic benefits' insurance" (2.3 mean value), and "Health care IRA--tax-free savings plan to fund personal health care" (2.5 mean value) were rated as being the most desirable for Montana. "State-administered health insurance" (5.7 mean value), "Managed care/limited provider networks [HMOs, PPOs]" (5.3 mean value), and "Federally-administered health insurance for all citizens" (5.0 mean value) received the least desirable ratings.

Another way to look at this data is by looking at those strategies which received the greatest number of "1" or "Most Desirable" ratings and the greatest number of "7" or "Least Desirable" ratings (Figure 11). The strategies which received the greatest number of "1" or "Most desirable" ratings by physicians were: "Incentives for employer-based health insurance coverage" (45%), "Offer more affordable "basic benefits" insurance" (42%), and "Healthcare IRA--tax-free savings plan to fund personal health care" (42%). The strategies which received the greatest number of "7" or "Least Desirable" ratings were: "State-administered health insurance for all citizens" (57%), "Managed care/limited provider networks" (39%), "Expand services for Medicaid and Expand Eligibility covered by Medicaid" (32%), and "Provide state-funded clinics for uninsured" (30%).

Physicians had a variety of recommendations for question 9 on how to increase access to health care for those persons who are unable to pay for their medical care (Appendix IV). Recommendations are categorized into the following topic headings with frequencies noted in parentheses: national health insurance (78), physician mandate (66), Medicaid/Medicare (66), tax incentives (38), patient responsibility (33), education and prevention (27), special clinics (26), rationing (24), liability and tort reform (12), insurance revisions (8), and bureaucracy (8) and other (19). As many of the comments dealt with more than 1 area, the full text of each comment has been arbitrarily assigned under only one of the headings in Appendix IV.

The number of physicians (23% of physicians answering question 9, or 15% of total survey physicians) who mentioned "national health insurance" in their recommendations (Question 9) may illustrate the need for change in our present health care delivery system. This percentage corresponds to the 24% of physicians who rated "federally-administered health insurance for all citizens" with either a "1 Most desirable" or "2 Second Most Desirable" in question 10.

FIGURE 10

Q10 STRATEGIES FOR ADDRESSING PROBLEMS

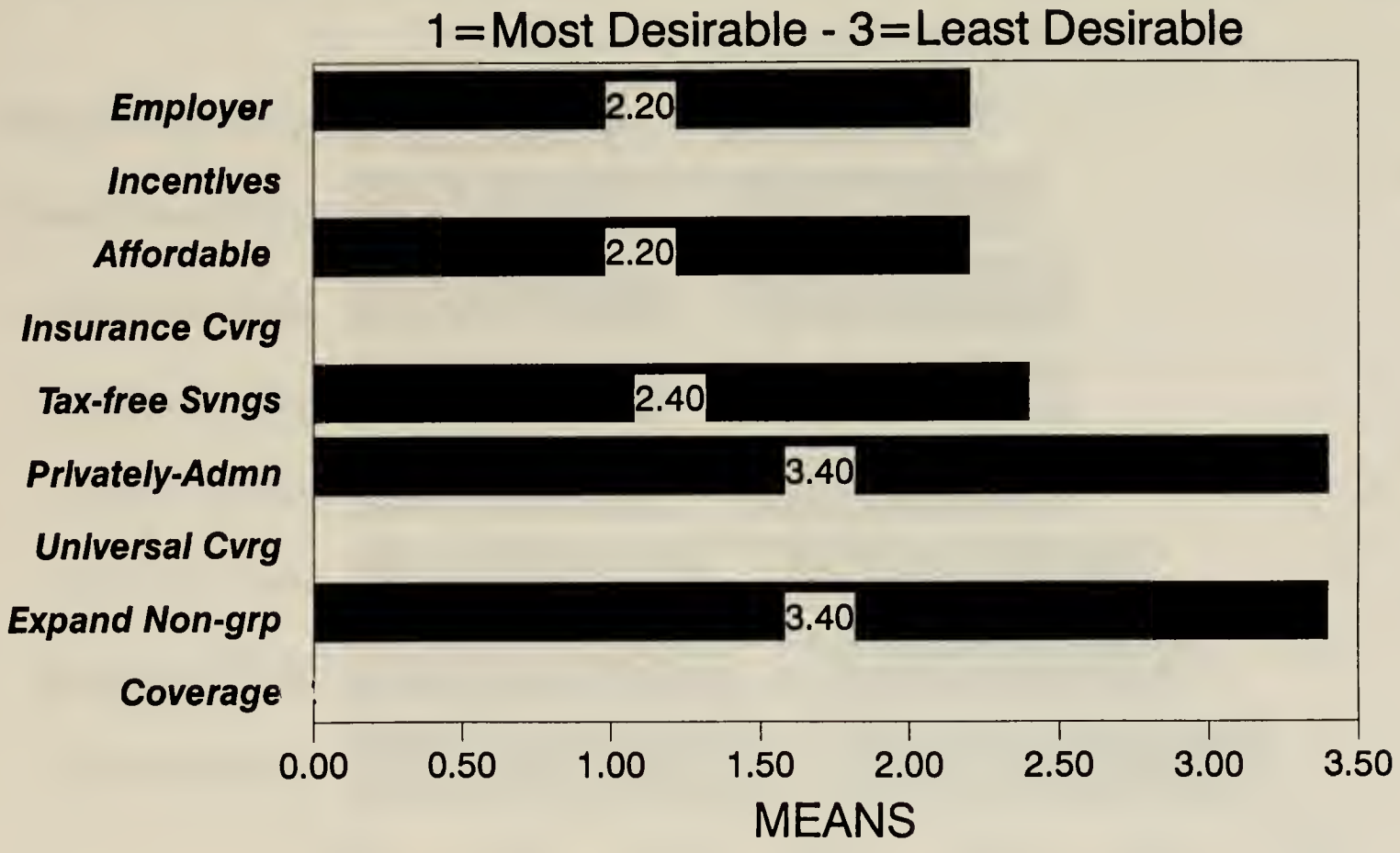


FIGURE 10 (Continued)

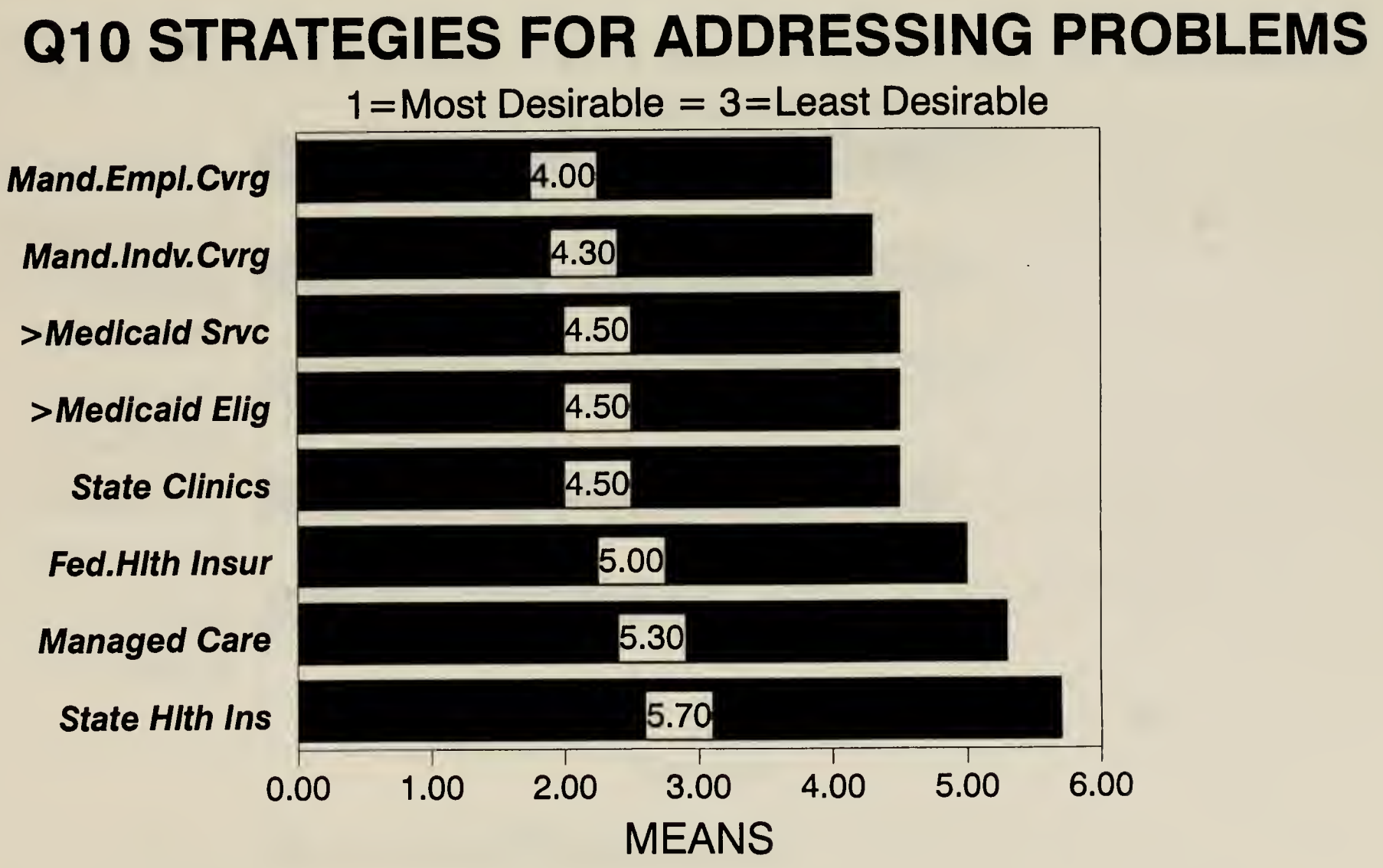


FIGURE 11

Q10 STRATEGIES FOR ADDRESSING PROBLEMS

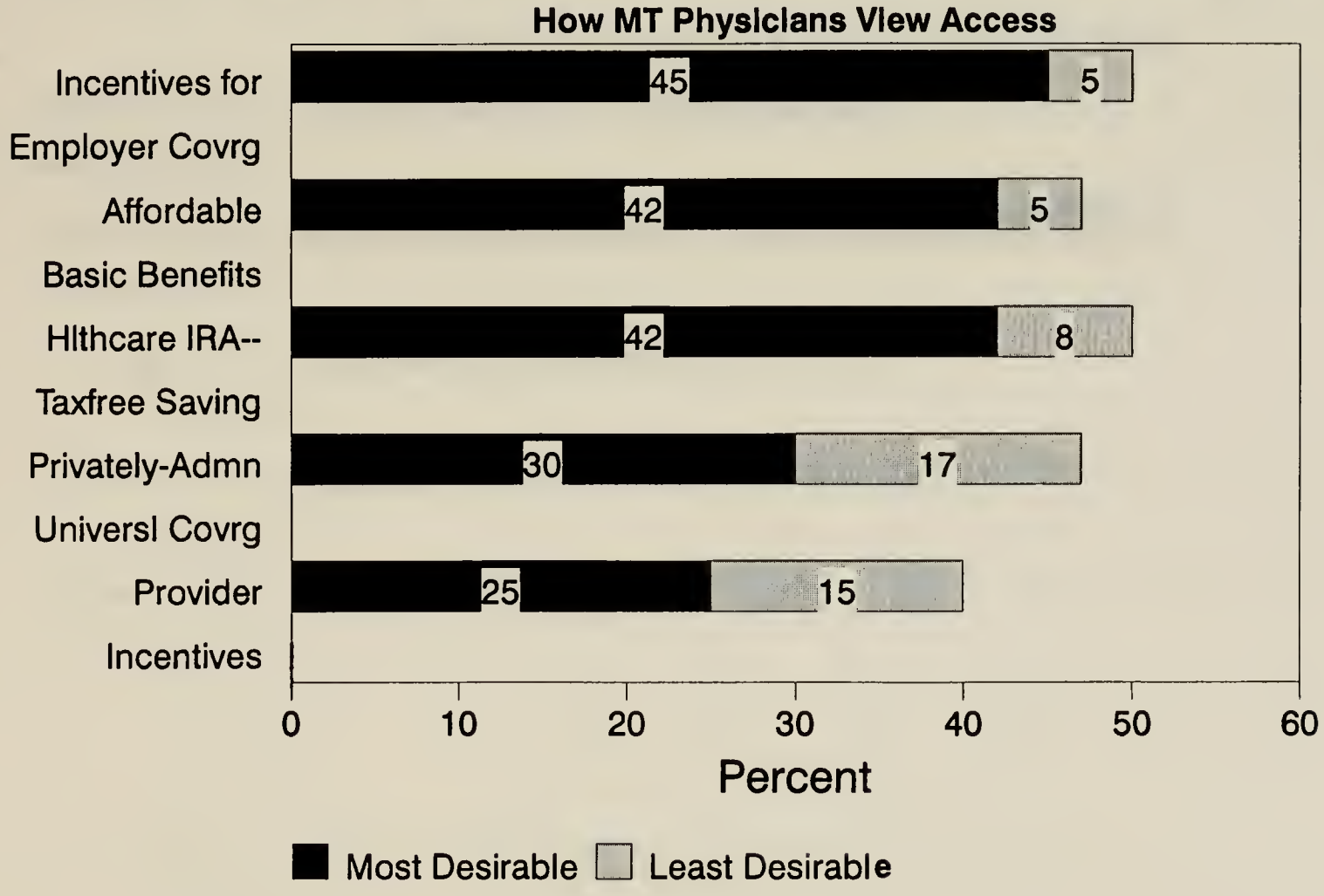
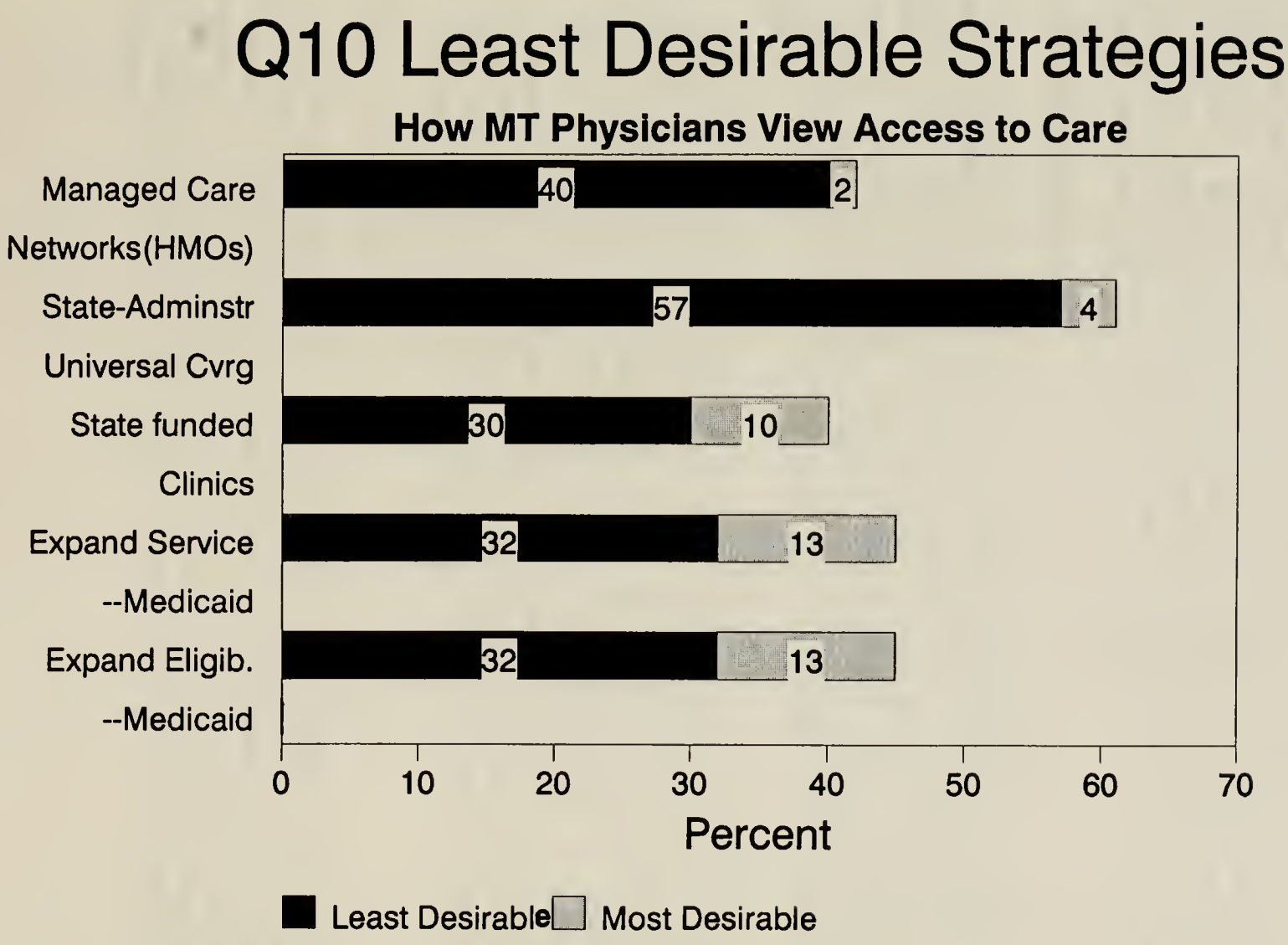


FIGURE 11 (CONT.)



A large number of respondents also suggested changes in the present Medicaid/Medicare provisions and encouraged development of a system with more incentives for self-responsibility or preventive health care. The physicians' sense of responsibility to provide care for those in need is reflected by the number of comments in Question 9 which indicated that they never refuse care, or the comments that all physicians should be involved in providing care to those without access. Several suggested that primary care physicians serve a gatekeeper role in assuring access to those needing services. Many of the comments dealt with ways to reduce health care costs--tort reform, insurance revisions, reducing bureaucracy and paperwork, rationing services, practicing preventive medicine and providing education, etc.

BENEFICIAL PROGRAMS

In (Figure 12, Question 11), the Department of Health's Immunization Program received the greatest percentage of "Very Beneficial" ratings (48%) even though 17% of the physicians were not familiar with the program (Figure 11). Medicare was rated as "Very Beneficial" by 40% of the physicians and as "Somewhat Beneficial" by 52%. Programs that were not familiar to over 40% of the survey physicians included the Montana Medically Needy Program, Montana Fluoride Swish, Montana Perinatal Program, and State Handicapped Children's Program.

A means was calculated for the ratings in Question 11 by weighting the frequencies for the 1 (Very Beneficial), 2 (Somewhat Beneficial), and 3 (Not Beneficial) responses and dividing the sum by the total number of responses. The "No Opinion" and "Not Familiar With" responses were not calculated in the means formula. Figure 13 shows that the Immunization program was again at the top of the list for being a beneficial program for patients with a means of 1.4, followed by the Handicapped Children's Program (1.57) and Women, Infants and Children Nutrition Supplemental Program [WIC](1.58). The means for all programs was between 1 and 2 which shows the programs are generally regarded by physicians as being very or somewhat beneficial.

DESIGN A PROGRAM

Comments for question 12: "If you were to design a program which would improve the health care of the underinsured, what would you do?" were similar to comments for question 9. Comments were categorized into the same categories as follows: national health insurance (53), insurance reform (46), tax incentives (41), patient responsibility (41), bureaucracy (39), education/prevention (32), liability/tort reform (17), rationing (13), special clinics (12), and physicians as gatekeepers (10).

FIGURE 12

Q11 PATIENT BENEFIT OF PROGRAMS

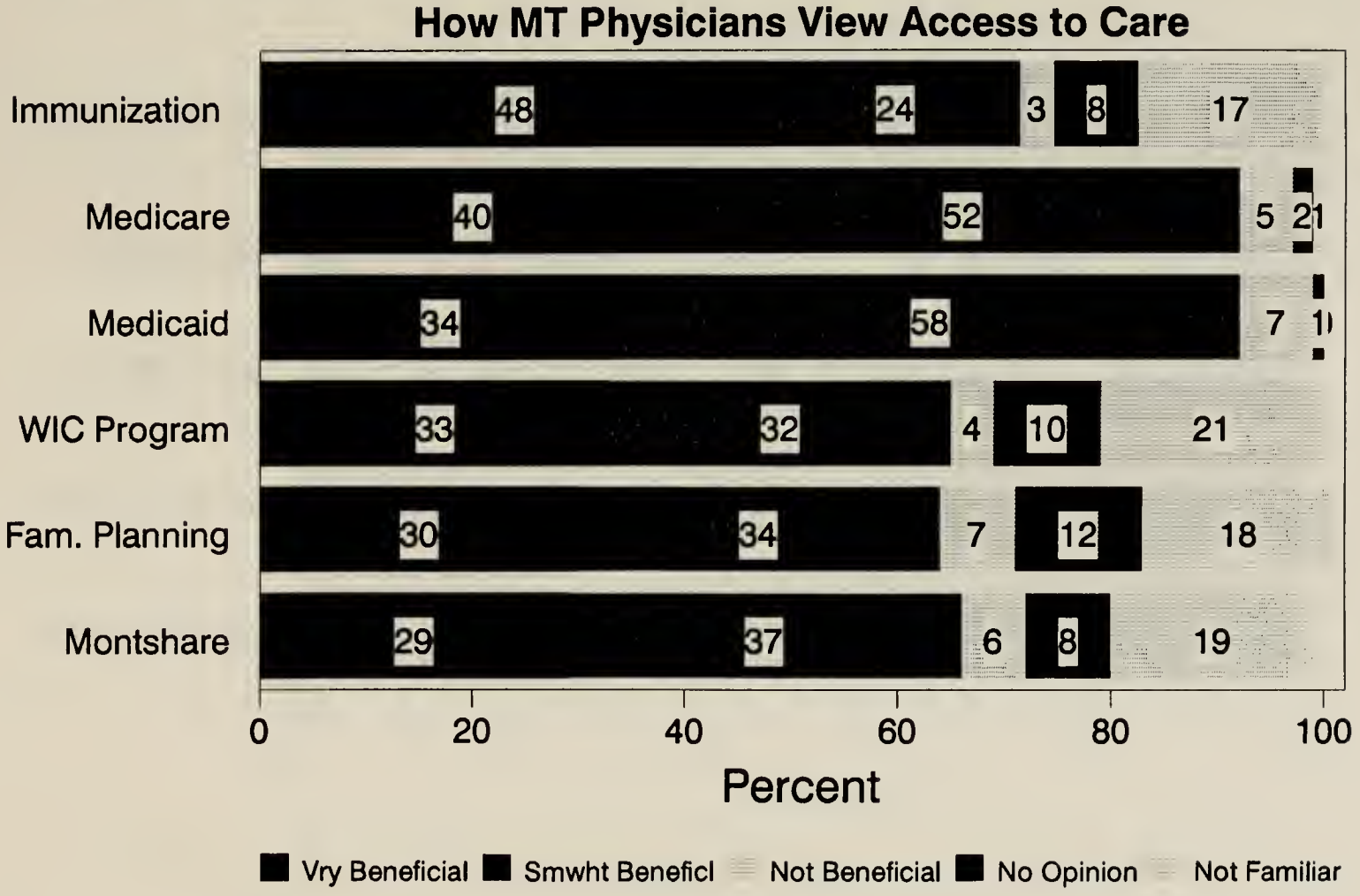
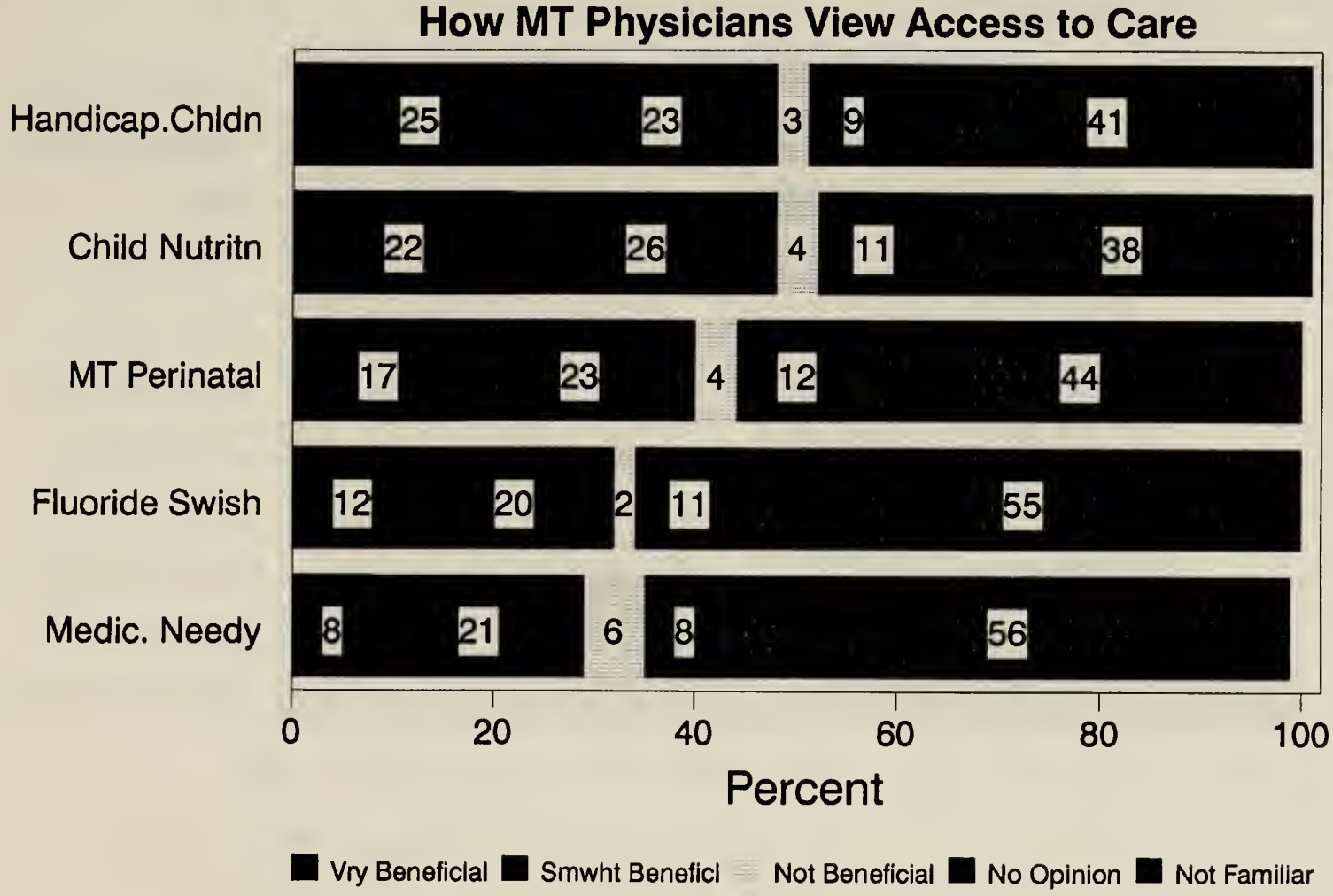


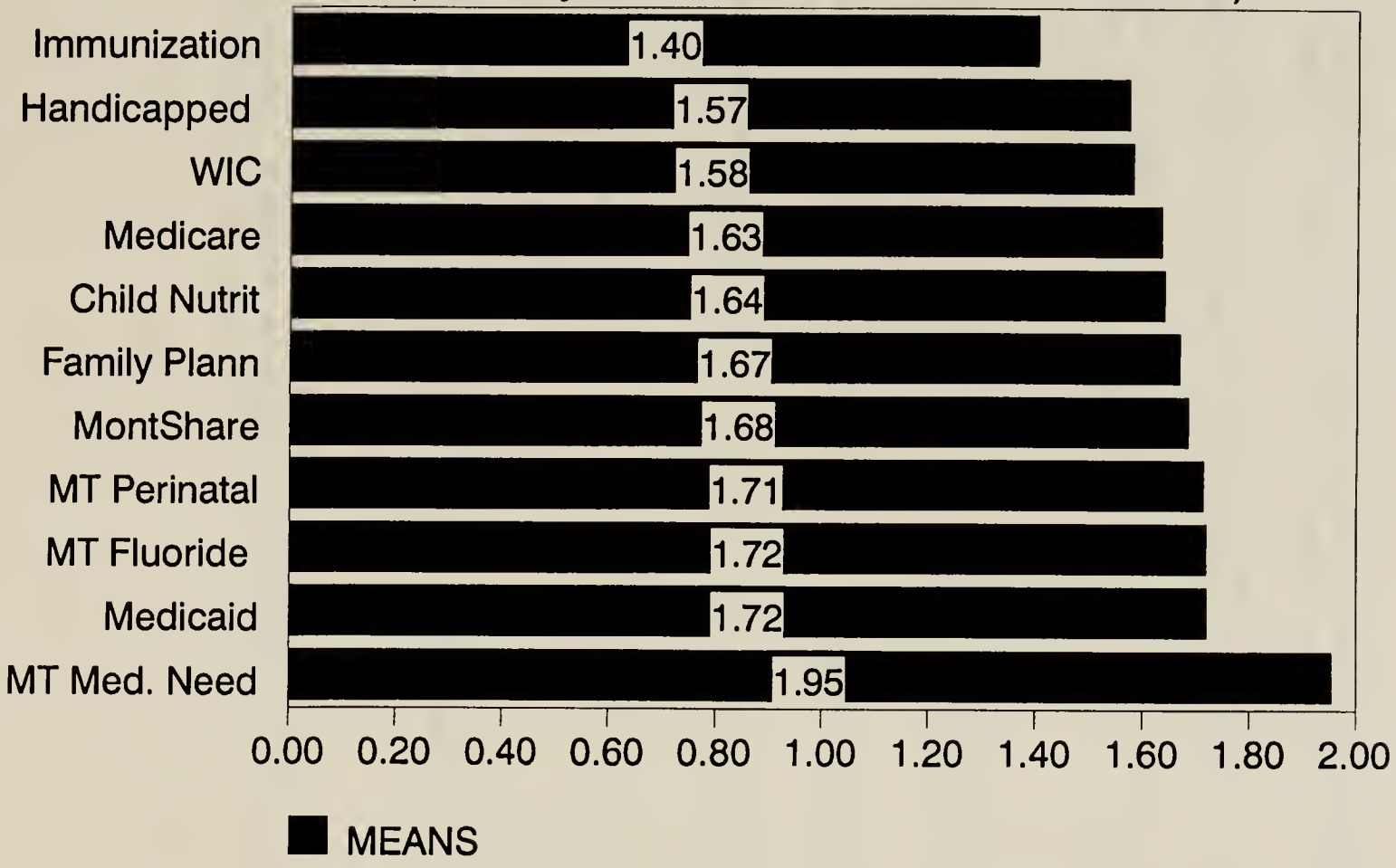
FIGURE 12 (CONT.)

Q11 PATIENT BENEFIT OF PROGRAMS



Q11 PATIENT BENEFIT OF PROGRAMS (MEANS)

(1=Very Beneficial - 3=Not Beneficial)



COMMENTS

In the final "Comments" section (Appendix V), physicians again commented on many of the same access issues, including:

* REDUCING THE BUREACRACY

"Avoid adding responsibilities to existing bureacracies which are inefficient, unresponsive, arrogant and irrelated from cause-effect relationships of the real world."

"Regulations are driving us out of business. Rural Montana hospitals are dying. That will devastate rural living, economies, and health care access."

"Too much waste in system. Those on Medicaid need to be monitored to avoid abuse, educated to tell when they need medical care."

* CHANGING SYSTEM INCENTIVES

"As it is now, the people who care about staying healthy and who don't abuse Medicare and Medicaid and who buy insurance, are subsidizing all the others. This is wrong and does not provide proper motivation."

" . . . free health care encourages unemployment . . . creates a demanding population that is nearly impossible to care for."

" . . .must not make 2nd class citizens of our needy patients (as does Medicaid), nor deny help to those in need."

" . . . encourage self responsibility through education so that tobacco and alcohol-drug induced illness is lessened."

* REDUCING HEALTH CARE COSTS

" . . .Clinics staffed with physician assistant's and nurse practitioners with referral to MD's when necessary would make more funds available to serve others."

". . . why not pilot test programs in several clinics?"

"The greatest impact program for reducing the cost of medical care would be significant tort reform . . remove the parasitic element of the legal profession, thus freeing up millions of dollars for health care."

* A NATIONAL HEALTH CARE SYSTEM

"Inevitably, there will be an expansion of federally or statewide support for health care and the sooner Montana can create an organization dedicated to planning, the better."

"Our system is not a system, but a patchwork of programs--some of them too political (i.e., I.H.S., V.A.). The system ultimately must be based on equity and justice, not the politics of entitlement."

Other comments were related to rationing, Medicare revisions, and the need for more "preventive" programs dealing with teenage pregnancy, family planning, other health promotion topics, or mental health services.

Letters from physicians with longer responses to open ended questions are included in Appendix VI.

SUMMARY AND CONCLUSIONS

The fact that 519 physicians responded to the questionnaire indicates a strong interest on the part of Montana providers to participate in the process of finding appropriate solutions to the multitude of problems associated with access to health care for all Montanans. The respondents represented an acceptable mix among physicians practicing in rural and non-rural communities.

The survey appears to be fully representative of the views of primary care physicians, since over 50 percent of physicians returning the questionnaire were primary care physicians. Primary care physicians comprise approximately 45 percent of the total physicians in Montana.

A summary of the basic questions provides the following physician perspective:

** Rated "HIGH" Priority for Federal and State Assistance Programs

- Infants and children (75% and 70% of Physicians)
- Pregnant women (64% of Physicians)
- Working poor (61% of Physicians)

**** Estimated Extent of Uncompensated Care**

- 20 percent of gross practice income is written off for charity and uncollected bills
- 29 percent of gross practice income is Medicare funded which generally reimburses below usual and customary charges
- 15 percent of gross practice income is Medicaid funded where reimbursement is approximately 50% of usual and customary charges.

**** Impact of Inability to Pay on Patient Care**

- Patients frequently fail to schedule follow-up visits (33% of Physicians)
- Patients frequently fail to follow prescribed therapy (28% of Physicians)
- Patients frequently delay treatment (26% of Physicians) which frequently results in more expensive treatment (18% of Physicians)

**** Implications of Inability to Pay on Physician Services**

- Full services provided regardless of ability to pay
- Time spent with patients would be equal or greater
- Order different and less expensive medication
- Order fewer laboratory and x-ray services

**** Solutions for Addressing Uninsured and Underinsured Problems which were rated "most desirable" for Montana**

- Provide incentives for employer insurance coverage (45% of Physicians)
- Offer more affordable "basic benefits" insurance (42% of Physicians)
- Provide for a individual tax-free savings plan for health care (42% of Physicians)
- Privately administered health insurance for all citizens (30% of Physicians)
- Increase incentives for providers to deliver more uncompensated care (25% of Physicians)

**** Least Desirable Approaches to Health Care Access**

- State administered health insurance for all citizens (57% of Physicians)
- Federally-administered health insurance for all citizens (53% of Physicians)
- Mangaged care/limited provider networks (HMOs, PPOs) (39% of Physicians)

**** Federal and State Programs Rated Very Beneficial to Health Care**

- Department of Health immunization programs (48% of Physicians)
- Medicare (40% of Physicians)
- Medicaid (34% of Physicians)
- Women, Infants, and Children (WIC) (33% of Physicians)
- Family planning (30% of Physicians)
- MMA MONTSHARE for the elderly (29% of Physicians)

Many of the physicians were unfamiliar with a number of federal and state assistance programs such as (1) handicapped children services, (2) child and adult care food services, (3) perinatal program to prevent low birthweight (4) dental services (fluoride treatment) for public school children, and (5) state "medically needy" program. This may indicate a need for state initiated educational programs to publicize the availability of these programs.

**** Recommendations for Improving Health Care Delivery**

- Review the concept of a national health insurance system
- Review Medicare and Medicaid programs
- Reduce inappropriate use of federal and state assistance programs
- Improve patient education programs in preventive medicine
- Provide appropriate tax incentives for physicians, patients, and businesses
- Provide for tort reform and reduce liability/insurance costs for health providers

APPENDIX I

MONTANA
HEALTH
EDUCATION
CENTER

Culbertson Hall, Room 308
Montana State University
Bozeman, MT 59717
(406) 994-6001 Fax (406) 994-6993

November 14, 1990

Dear Colleague,

The enclosed survey has been developed to give you an opportunity to voice your concerns and provide recommendations regarding access to health care in Montana.

A group of Montana legislators, informally co-chaired by Judy Jacobson and Fred Thomas, has begun serious consideration of the uninsured/underinsured problem in Montana. They would like your help in identifying the breadth of the problem in Montana as well as your ideas on solutions. The survey results will also be shared with the Governor's committees studying health insurance and health care options.

Your input is very important. We appreciate that your time is limited, so the survey has been designed to be simple and brief. Please take a couple of minutes to complete this survey.

Thank you very much for your interest and assistance.

Sincerely yours,

R. J. Flaherty MD

Robert J. Flaherty, M.D.
Medical Associates, PC

Marjorie C. Levine

Marjorie C. Levine, M.S., R.D.
Program Coordiantor, MT AHEC

HOW MONTANA PHYSICIANS VIEW ACCESS TO HEALTH CARE

1. **In what size community is your practice? Population of**

_____a. Under 10,000
_____b. 10,000 - 24,999
_____c. 25,000 - 49,999
_____d. 50,000 or more

2. **Please check the SPECIALTY which best describes your practice:**

_____a. Family/General Practice
_____b. General Internal Medicine
_____c. Obstetrics/Gynecology
_____d. Pediatrics
_____e. Opthalmology
_____f. Psychiatry
_____g. Surgery
_____h. Other Specialty

3. **What is the zip code of the community in which you practice?**_____

4. **Please check the description which best describes your situation?**

_____a. Actively practicing medicine
_____b. Research/teaching
_____c. Administration/government
_____d. Retired
_____e. Other _____

5. **What priority should the following groups be given for federal and state health care assistance programs?**
1 = High Priority 2 = Moderate Priority 3 = Low Priority 4 = No Opinion

_____a. Unemployed
_____b. Working poor
_____c. Self-employed
_____d. Workers in industries such as agriculture or timber
_____e. Migrant workers
_____f. Small business employees
_____g. Pregnant women
_____h. Infants
_____i. Children
_____j. Adolescents
_____k. Elderly
_____l. Minorities
_____m. Mentally Ill
_____n. Chronically Ill
_____o. Handicapped
_____p. Other _____

6. **What <u>percentage</u> of your gross practice income is**

_____a. Medicare payments

_____b. Medicaid payments

_____c. Paid by private insurance company

_____d. Paid for by individual or private party

_____e. "Charity care" (voluntary reduction in your charges)

_____f. Billed for, but not collected (ie., portion that insurance company or private payer does not cover)

7. **Because of inability to pay, how often do you feel your patients**
1 = NEVER 2 = SOMETIMES 3 = FREQUENTLY

_____a. Delay receiving medical treatment

_____b. Do not fill a prescription

_____c. End up needing more expensive care as a result of delaying a visit

_____d. Do not follow prescribed therapy

_____e. Do not schedule follow-up visits

_____f. Adopt healthy lifestyles/follow good preventive measures

8. **How frequently do you do the following because you know the patient is unable to pay?** *1 = NEVER 2 = OCCASIONALLY 3 = FREQUENTLY*

_____a. Spend less time with patient

_____b. Will not see patient for non-emergency cases

_____c. Order different, less expensive medication

_____d. Recommend fewer follow-up appointments

_____e. Treat patient in less sympathetic manner

_____f. Treat patient in more sympathetic manner

_____g. Order fewer lab/x-ray tests

_____h. Refer to another physician

_____i. Refer to agency (local health department, family planning, etc.)

_____j. Other _____

9. **What recommendations do you have for increasing access to health care for those persons who are unable to pay for their medical care?**

10. **How would you rate (1-7) the following strategies for addressing the uninsured/underinsured problem?**
(1 = Most desirable for Montana - 7 = Least desirable for Montana)

_____a. Federally-administered health insurance for all citizens

_____b. State-administered health insurance for all citizens

_____c. Privately-administered health insurance for all citizens

_____d. Expand eligibility for Medicaid

_____e. Expand services covered by Medicaid

_____f. Mandate individual health insurance coverage (like auto liability insurance is required to license a car)

_____g. Mandate employer-based health insurance coverage

_____h. Incentives for employer-based health insurance coverage

_____i. Managed care/limited provider networks (HMOs, PPOs)

_____j. Offer more affordable "basic benefits" insurance

_____k. Health care IRA--tax-free savings plan to fund personal health care

_____l. Expand nongroup coverage, such as state risk pools for insuring diabetics

_____m. Incentives for providers to deliver more uncompensated care

_____n. Provide state-funded clinics for uninsured

_____o. Other_____

11. **How would you rate the following programs in terms of benefit to your patients?**
1 = Very Beneficial 2 = Somewhat Beneficial 3 = Not Beneficial
4 = No Opinion 5 = Not Familiar With

_____a. Medicaid

_____b. Medicare

_____c. Montana Medically Needy Program

_____d. Montana Perinatal Program (Low Birthweight, Miami, etc.)

_____e. Family Planning

_____f. Department of Health Immunization Program

_____g. WIC Program (Women, Infants, Children Nutrition)

_____h. Child Nutrition Program (Child & Adult Care Food Program)

_____i. State Handicapped Childrens Program

_____j. Montana Medical Association Montshare Program

_____k. Montana Dental Program (Fluoride Swish, etc.)

_____l. OTHER_____

12. **If you were to design a program which would improve the health care of the underinsured, what would you do?**

Please add any comments!!!!!

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS SURVEY!

Please return the completed survey by December 1, 1990 in the enclosed addressed/stamped envelope to the:

Montana Area Health Education Center
308 Culbertson Hall
Montana State University
Bozeman, MT 59717

APPENDIX II

HOW MONTANA PHYSICIANS VIEW ACCESS TO HEALTH CARE
Frequency/Percentage Raw Data
December 1990

1. In what size community is your practice? Population of

FREQ	%		FREQ	%	
108	21.5	a. Under 10,000	118	23.5	c. 25,000 - 49,999
60	11.9	b. 10,000-24,999	217	43.1	d. 50,000 or more

Missing 4

2. Please check the SPECIALTY which best describes your practice:

FREQ	%		FREQ	%	
144	28.6	a. Family/General Practice	14	2.8	e. Opthalmology
60	11.9	b. General Int. Medicine	15	3.0	f. Psychiarty
30	6.0	c. Obstetrics/ Gynecology	44	8.7	g. Surgery
28	5.6	d. Pediatrics	169	33.5	h. Other

Missing 3

3. What is the zip code of the community in which you practice?

4. Please check the description which best describes your situation?

FREQ	%		FREQ	%	
460	91.3	a. Actively practicing medicine	34	6.7	d. Retired
1	.2	b. Research/teaching	5	1.0	e. Other
4	.8	c. Administration/ government + P.h.		.2	f. Semi-retired

Missing 3

5. What priority should the following groups be given for federal and state health care assistance programs?
1= High Priority 2=Moderate Priority 3= Low Priority 4= No Opinion

Percent of Physicians 1	2	3	4	Missing Freq.	
31.7	44.3	20.9	3.1	53	a. Unemployed
60.7	33.3	4.9	1.1	39	b. Working poor
10.1	32.9	49.3	7.7	63	c. Self-employed
9.3	34.8	48.2	7.7	65	d. Workers in industries such as ag. or timber
16.5	42.9	32.5	8.1	64	e. Migrant workers

11.4	42.2	41.1	5.3	76	f. Small business employees
63.5	23.8	7.6	5.0	49	g. Pregnant women
75.2	18.1	3.7	3.1	48	h. Infants
69.7	23.5	3.7	3.1	52	i. Children
38.2	40.4	16.3	5.1	59	j. Adolescents
26.8	48.2	21.7	3.3	59	k. Elderly
12.6	39.1	31.9	16.5	77	l. Minorities
33.1	48.4	13.1	5.3	57	m. Mentally Ill
28.2	53.2	13.4	5.1	60	n. Chronically Ill
38.3	47.8	8.5	5.4	61	o. Handicapped
51.6	19.4	6.5	22.6	476	p. Other

6. What **percentage** of your gross practice income is

Mean	
28.5%	a. Medicare payments
14.7%	b. Medicaid payments
34.7%	c. Paid by private insurance company
16.4%	d. Paid for by individual or private party
9.3%	e."Charity care" (voluntary reduction in your charges)
10.7%	f. Billed for, but not collected (ie., portion that insurance company or private payer does not cover)

7. Because of inability to pay, how often do you feel your patients 1= NEVER 2 = SOMETIMES 3= FREQUENTLY

Percent of Physicians				
1	2	3	Missing	
11.4	62.9	25.6	35	a. Delay receiving medical treatment
7.1	70.5	22.4	43	b. Do not fill a prescription
8.7	73.2	18.1	48	c. End up needing more expensive care as a result of delaying a visit
5.8	66.5	27.7	45	d. Do not follow prescribed therapy
6.5	60.3	33.2	46	e. Do not schedule follow-up visits
40.0	51.7	8.4	54	f. Adopt healthy lifestyles/follow good preventive measures

8. How frequently do you do the following because you know the patient is unable to pay? **1=NEVER 2=OCCASIONALLY 3=FREQUENTLY**

Percent of Physicians				
1	2	3	Missing Freq.	
83.1	15.2	1.7	40	a. Spend less time with patient
76.3	21.3	2.4	43	b. Will not see patient for non-emergency cases
18.9	43.7	37.4	42	c. Order different, less expensive medication
46.1	43.0	10.9	49	d. Recommend fewer follow-up

				appointments
90.5	9.3	0.2	45	e. Treat patient in less sympathetic manner
46.4	42.0	11.6	50	f. Treat patient in more sympathetic manner
20.9	58.1	20.9	39	g. Order fewer lab/x-ray tests
80.6	18.3	1.1	54	h. Refer to another physician
28.3	54.4	17.3	55	i. Refer to agency (local health dept., family planning, etc.)
8.7	30.4	60.9	484	j. Other

9. What recommendations do you have for increasing access to health care for those persons who are unable to pay for their medical care?

See categorized listing of Question 9 Recommendations in Appendix IV.

10. How would you rate (1-7) the following strategies for addressing the uninsured/underinsured problem?

(1 = Most desirable for Montana - 7 = Least desirable for Montana)

Percent of Physicians 1	1+2	6+7	7	Mean	Missing	
16.1	23.9	59.5	53.0	5.0	60	a. Fed.-admin. hlth ins. for all citizens
3.9	10.5	68.3	57.4	5.7	66	b. State-admin. hlth. ins. for all citizens
29.6	44.3	22.2	16.5	3.4	71	c. Privately-admin. hlth ins. for all citizens
13.0	23.5	41.6	32.0	4.5	69	d. Expand eligibility for Medicaid
12.6	24.1	43.1	31.8	4.5	64	e. Expand services covered by Medicaid
16.8	27.1	37.5	27.7	4.3	78	f. Mandate ind hlth insur. coverage (like auto liability insur. is required to license a car)
14.0	29.1	31.0	21.8	4.0	71	g. Mandate employer-based hlth insur. coverage
45.1	72.3	6.9	4.9	2.2	55	h. Incentives for employer-based health insurance coverage
2.3	9.1	54.5	39.3	5.3	67	i. Managed care/limited provider networks (HMOs, PPOs)
42.3	70.9	6.6	5.0	2.2	67	j. Offer more affordable "basic benefits"

						insurance Coverage
41.5	65.7	9.8	7.9	2.4	78	k. Hlth care IRA-tax-free savings plan to fund personal hlth care
17.5	38.1	17.9	12.1	3.4	95	l. Expand nongroup coverage, such as state risk pools for insuring diabetics
24.5	47.9	20.9	14.7	3.2	71	m. Incentives for providers to deliver more uncompensated care
10.1	24.5	42.5	30.4	4.5	70	n. Provide state-funded clinics for uninsured
76.9	84.6	12.8	12.8	1.8	468	o. Other

11. How would you rate the following programs in terms of benefit to your patients? **1= Very Beneficial 2= Somewhat Beneficial 3=Not Beneficial 4=No Opinion 5= Not Familiar With**

Percent of Physicians					Missing		
1	2	3	4	5	Freq.	Mean	
34.3	57.8	6.8	0.7	0.2	50	1.72	a. Medicaid
40.4	51.5	4.8	1.8	1.3	51	1.63	b. Medicare
7.9	21.4	6.3	7.9	56.4	78	1.95	c. MT Med Needy Prg.
16.9	22.5	4.4	12.3	44.0	75	1.71	d. MT Perinatal Prg. (low birthweight, MIAMI Project)
29.8	33.5	6.7	11.9	18.1	71	1.67	e. Family Planning
47.9	23.5	3.2	8.0	17.1	69	1.40	f. Dept of Hlth Immunization Prog.
33.3	31.5	4.3	9.5	21.4	63	1.58	g. WIC Program (Women, Infants, Children Nutrition)
22.1	26.1	3.5	10.5	37.8	78	1.64	h. Child Nutrit. Prog. (Child & Adult Care Program)
24.5	23.3	2.8	8.6	40.6	78	1.57	i. State Handicapped Childrens Program
29.2	36.7	6.4	8.4	19.1	68	1.68	j. MT Med Assoc Montshare
12.0	19.9	2.4	11.0	54.7	90	1.72	k. MT Dental Pgrm (Fluoride Swish)
60.0	40.0				502		l. OTHER

12. If you were to design a program which would improve the health care of the underinsured, what would you do?

See Appendix IV for Listing of Question 12 responses.

APPENDIX III

2. Please check the SPECIALTY which best describes your practice:

Q2OTHER

ANESTHESIOLOGY 5
DERMATOLOGY 3
ORTHOPEDICS 7
ORTHOPEDIC SURGERY 2
NEUROSURGERY 2
ENT. 2
GASTROENTEROLOGY 1
EMERGENCY MEDICINE 9
EMERGENCY ROOM (ER) 3
ALLERGY 1
GERIATRIC 1
RADIOLOGY 4
CARDIOLOGY 1
CARDIOVASCULAR 1
PULMONARY 2
PULM. DISEASES 1
UROLOGY 3
STUDENT (COLLEGE) HEALTH 2
PSYCHIATRY 2
ADMINISTRATIVE 1
PHYSICAL MEDICINE 1
PUBLIC HEALTH 1
NEUROLOGY 2
PATHOLOGY 2
INTERNAL MEDICINE 1
NUCLEAR MEDICINE 1
REHABILITATION 2
ONCOLOGY 1
YES, BUT DID NOT SPECIFY 1

5. What priority should the following groups be given for federal and state health care assistance programs?

Q5OTHER

NATIONAL HEALTH CARE FOR ALL CITIZENS 3

UNDERINSURED OR UNINSURED (MENTALLY ILL, CHRONIC ILLNESS, TRAUMA IN UNINSURED) 4

CATASTROPHIC ILLNESS 2

HOMELESS 1

SINGLE PARENTS 1

PRISONERS 1

INDIAN AND OTHER HEALTH RESOURCES 1

ABLE-DISABLED 1

AIDS 1

CONTRACEPTIVE CARE 1

ELDERLY WITHOUT MEDICARE 1

NO WORK - NO WELFARE 1

8. How frequently do you do the following because you know the patient is unable to pay? 1=NEVER 2=OCCASIONALLY 3=FREQUENTLY

Q8OTHER

GIVE OUT PHARMACEUTICAL SAMPLES AS AVAILABLE 4

DO NOT CHARGE PATIENT OR DRASTICALLY REDUCE FEE 4

ACCEPT MEDICAID PAYMENTS THAT WILL NOT COVER OVERHEAD 1

MENTAL HEALTH CENTER 2

FIND OTHER FUNDING SOURCES-REFER TO FOOD BANK, WELFARE, SALVATION ARMY, HOSPICE 2

UTILIZE MECHANISMS TO KEEP COST DOWN (CHEAPER MEDICATIONS, BETTER ORGANIZATION) 3

CHARGE OTHER PAYING PATIENTS MORE SO THE CLINIC CAN BREAK EVEN 1

TREAT REAL DISEASE, NOT COSMETIC PROBLEMS 1

LOW VISION CLINIC REFERRAL 1

DISCUSS COSTS AND TREATMENT - ATTEMPT TO REACH AGREEABLE PLAN 1

IF PATIENTS HAVE THE MONEY THEY SHOULD PAY NOT BLOW IT 1

WE TRY TO PROVIDE THE SAME LEVEL REGARDLESS OF INCOME 1

10. How would you rate (1-7) the following strategies for addressing the uninsured/underinsured problem?
(1 = Most desirable for Montana - 7 = Least desirable for Montana)

Q10OTHER

RESPONDENT #	
23	DON'T ALLOW INSURANCE COMPANIES TO DENY PAYMENT OF CLAIMS WITHOUT MAKING THEM RESPONSIBLE FOR PUNITIVE DAMAGES. IF RECENT SUPREME COURT RULING IS ALLOWED TO STAND UNCONTESTED BY STATE INSURANCE DEPARTMENTS THEN THE INSURANCE COMPANIES WILL MAKE DENYING CLAIMS SOP AND MOST CITIZENS WILL BE RIPPED OFF ON POLICIES THEY ALREADY PAY TOO MUCH FOR.
25	IDENTIFY INDIVIDUALS FOR PRACTITIONER
35	PRIORITY SYSTEM FOR MEDICAID SPENDING SIMILIAR TO OREGON'S
37	RATE SMOKERS AND DRINKERS W/HI INS.RATES FOR HLTH INS.
38	PEOPLE NEED TO BE RESPONSIBLE & PROVIDE FOR HLTH COVERAGE
41	THIS IS A POLITICAL QUESTION UNFORTUNATELY
46	FIND CARE LIQOUR,GAS,CIGARETTE,TOBACCO TAXES-NOT INCOME TAX
60	SPEND MORE FOR EDUC.REGARD.PRIORITIZATION OF HLTH CARE
77	ST & NAT'L RATIONING PROGRAM IE OREGON. ELIMINATE TORT SYS.
90	NAT'L HLTH INS.STANDARDS-INS.PROVIDED BY PRIVATE COMPANIES.
92	CAP MEDICAL MALPRACTICE
98	ANY ST OF FED.BUREAU. SOLUTION WILL BE INEFFICIENT & EXPENS.
120	ALLIED HLTH PROFESSIONALS PROVIDE CARE AT LESS COST.
122	TORT REFORM MEASURES TO DIMINISH THE TEND.TO PRAC DEF.MED.
141	MORE INDIVIDUAL ACCOUNTABILITY FOR UNHEALTHY LIFESTYLES
147	INCREASE CURRENT MEDICARE/MEDICAID RATES
164	EFFICIENT MEDICAID ADMINISTRATION (USE CIGARETTE TAX)

178 MAKE M/CAID REIMBUR.MORE REALISTIC SO PROVIDERS WILL ACCEPT

197 COMMUNITY-WIDE VOLUNTEER FREE CLINICS

207 STOP WELFARE PMTS TO THOSE W/CHILDREN CONT. TO HAVE CHILDREN

219 INCREASE AMT PAID TO PROVIDERS BY MEDICAID/MEDICARE

226 FUND PUBLIC CLINICS & HOSPITALS FOR ANYONE UNABLE TO PAY

238 BENEFITS FOR PEOPLE DOING HEALTHY THINGS (IE,EXERCISE)

275 EACH PERSON SHOULD PAY SOMETHING NO MATTER HOW SMALL

278 DIRECT TAX INCENTIVES FOR FREE CARE TO ST.AUTHORIZED PTS.

290 IT IS TOO EASY TO BECOME MEDICAID ELIGIBLE IN THIS STATE

300 NAT'L HLTH PLAN/PROGRAM-NEED TO RATION CARE

304 MEDICARE BENEFITS BASED ON NEED

305 ADEQUATELY REIMBURSE PROVIDERS FOR MEDICAID

312 BOOST PREVENTATIVE MEDICINE PROGRAMS

320 INC.PMT FOR MEDICAID PTS TO 80%. PRESENT IS ONLY 50% OR LESS

322 CATASTROPHIC HEALTH INSURANCE

327 TABACCO TAX ALCOHOL TAX TO COVER DIRECT HEALTH COSTS

339 IMPROVE MEDICAID REIMBURSEMENT TO MD'S INCREASES INCENTIVE.

342 HEALTH INSURANCE SHOULD NOT BE ELECTIVE.

351 DECREASE DEMAND.

359 GET GOVERNMENT OUT OF HEALTH CARE

365 A STATE OR FEDERAL INS. FOR PEOPLE WITH LOW INCOMES.

368 MAKE MEDICARE A MEANS-TESTED PROGRAM

369 FEDERALLY ADMINISTERED "LEGAL" INSURANCE FOR ALL

393 NO WORK/NO WELFARE

404 RESTRICT ELIGIBILITY FOR MEDICARE

422 MARKED INCREASE IN PUBLIC HEALTH ACTIVITIES

429 TRY OUT SOCIALIZED MEDICARE

444 PROVIDE JOBS WITH ADEQUATE HEALTH INSURANCE

454 CATASTROPHIC COMPREHENSIVE COVERAGE BY FED OR STATE.

458 GET THE GOVT OUT OF HEALTH CARE.

460 GIVE PHYSICIANS & HOSPITALS TAX WRITE-OFFS FOR LOST MONIES.

463 NON-PROFIT INSTITUTIONAL FUNDING FOR CLINICS FOR THE POOR.

503 WHERE WILL STATE SECURE MONEY FOR HEALTH PROGRAMS?

11. How would you rate the following programs in terms of benefit to your patients? 1=Very Beneficial 2=Somewhat Beneficial 3=Not Beneficial 4=No Opinion 5=Not Familiar With

Q11OTHER

1 VISUAL SERVICES

37 VISUAL SERVICES PROGRAMS ALSO LOW VISION CLINIC

226 PUBLIC CLINICS & HOSPITALS FOR THOSE UNABLE TO PAY.

231 MY PTS ALL HAVE THEIR CARE PAID FOR.

403 WORKER'S COMPENSATION

425 VARIOUS SERVICE CLUBS

APPENDIX IV

Q9. What recommendations do you have for increasing access to health care for those persons who are unable to pay for their medical care?

BUREAUCRACY

RESPONDENT #

350 CUT DOWN THE NUMBER OF PEOPLE IN THE ADMINISTRATION OF THE FUNDS AND PROVIDE MORE TO THE RECIPIENTS. THIS IS THE AGE OF COMPUTERS AND LESS EMPLOYEES.

458 GET THE GOVT OUT OF HEALTH CARE. THIS WOULD DECREASE THE TREMENDOUS COST OF MAINTAINING A PAPERWORK BUREAUCRACY IN ORDER TO SATISFY THE GOVT. I HAVE NO PROBLEM TAKING CARE OF PEOPLE WHO CANNOT PAY. ITS THE GOVT. HASSLE THAT MAKES ACCESS AN ISSUE.

461 GET THE GOVT OUT OF MEDICAL CARE & THE HEALTH CARE PROVIDERS WILL RESUME CARING FOR EVERYONE.

359 KEEP IT IN THE PRIVATE SECTOR. GOVERNMENT INTERVENTION CAN ONLY MAKE THE SITUATION WORSE. SOCIALISM HAS BEEN PROVEN TO FAIL, AND ALWAYS WILL FAIL. LET CHARITY, GOOD WILL AND HUMAN KINDNESS WORK.

482 LET STATES MANAGE IT.

326 SPEND LESS TIME & MONEY ON THE BUREAUCRACY, PAPER WORK, LAWYERS & ANYONE BUT THOSE WHO ACTUALLY DELIVER THE CARE. I SPEND 15% COLLECTING EACH MEDICAID BILL OVER & ABOVE WHAT IT COSTS TO COLLECT ANY OTHER CHARGE FROM MY OFFICE.

384 STOP PAYING FOR FOREIGN MILITARY INTERVENTIONS & FOR MILITARY SUPPORT OF FOREIGN ALLIES. INSTITUTE COMPREHENSIVE COST CONTAINMENT INCLUDING GOV'T OVERSIGHT &, IF NECESSARY, PRICE/PROFIT LIMITS ON SOME MANUFACTURERS & INSURANCE COMPANIES.

500 WHAT I SUGGEST DOESN'T MATTER. THE FEDERAL/STATE BUREAUCRATS WILL COME UP WITH THEIR ANSWERS/SOLUTIONS WHICH WONT BE MUCH.

SPECIAL CLINICS

329 START PILOT PROJECT BY COMPETENT MEDICAID ORGANIZERS EITHER STATE WIDE OR IN COUNTY WIDE.

342 PROVIDE PUBLIC CLINICS FOR LIMITED GROUP OF PATIENTS. STATE WOULD BE EXEMPT FROM MALPRACTICE COSTS AND COULD BUY SUPPLIES CHEAPER.

221 FREE OR LOW COST CLINICS-MANNED BY VOLUNTEER M.D. ON A ROTATIONAL BASIS(SIMILAR TO CALL SCHEDULE). ALL PHYS.SHOULD BE WILLING TO WORK A FEW DAYS A YEAR WITH NO PAY. THIS WOULD HELP-WE ALL NEED TO PARTICIPATE.

75 CLINICS, RATHER THAN ACCESSING PRIVATE CARE.

344 ESTABLISH STATE OR FEDERALLY FUNDED CLINICS WHERE PROVIDERS CAN WORK FOR A SALARY & PROVIDE CARE FOR THE NOW INSURED. THE PROVIDER SHOULD HAVE A SALARY WHICH WOULD MAKE IT APPETIZING TO WORK IN THIS SETTING. ALSO PAID MALPRACTICE & MEDICAL INSURANCE.

277 EVERYONE NEEDS COVERAGE. COMMUNITY CLEARINGHOUSE FOR PTS & REFERRAL TO APPROPRIATE PHYS. W/POOL OF PHYS.WHO WOULD ACCEPT PT. HOSPITAL DIAGNOSTIC SERVICES MIGHT BE OFFERED AT LESS OR NO COST. DEFINING WHO BELONGS TO COMMUNITY WOULD BE A PROBLEM.

123 FOR SOME GROUPS STATE FUNDED CLINICS MEETING AT SPECIFIC TIMES FOR CHECK-UPS AND CARE OF CHRONIC PROBLEMS. RUN BY LOCAL OR STATE PHYSICIANS.

197 FREE CLINICS STAFFED BY VOLUNTEER PHYS./NURSES, IN PUBLIC OR COUNTY HLTH FACILITIES IN LARGER CITIES(MISSOULA,ETC.). IT WOULD REQUIRE ONLY 1-3 PHYS. DAYS/YEAR FOR EACH IF MOST PRIMARY CARE PHYS. VOLUNTEERED.

353 GET LOW INCOME AGENCIES TO WORK TOGETHER NOT SEPARATE.

473 GOVT FUNDED CLINIC WHERE INTERESTED MD'S & RN'S & OTHERS WORK PART TIME FOR PHILANTHROPIC REASONS, BUT REIMBURSED SOMEWHAT.

290 INCREASING PUBLIC HLTH DEPT. FUNDING SO PUBLIC HLTH NURSES COULD STAFF A NON-WELFARE, UNDER-INSURED ACUTE HTLH CARE CLINIC.

260 LOCAL VOLUNTARY CHARITY CLINICS RUN IN A PUBLIC FACILITY BY PHYSICIANS WHO SIMPLY DONATE THEIR TIME ON A PURELY VOLUNTARY BASIS.

422 PLANNED PARENTHOOD ASKED ME TO VOLUNTEER MY TIME TO CLINICS THAT WOULD PROVIDE FREE CARE. MED SOCIETIES OR CHURCHES SHOULD RUN FREE CLINICS. TO MUCH BUREAUCRACY. GOV NEEDS TO REALIZE ITS MUCH MORE DIFF & TIME CONSUMING TO CARE FOR THE POOR & PAY MORE.

454 PRESENTLY WORKING WITH COMM. TO ENABLE ACCESS TO HEALTH CARE ON A COOPERATIVE VENTURE BETWEEN COUNTY & HEALTH CARE GIVER. NEGOTIATED SYSTEM WHERE ALL ASPECTS ARE CONSIDERED. SOCIETY SHOULD PROVIDE FUNDING FOR MEDICALLY INDIGENT OR HEALTH CARE PROV.

336 PUBLIC HEALTH CLINICS. PARTIAL ASSISTANCE BASED ON INCOME. CHARITY WRITE-OFF FOR PHYSICIANS. ADEQUATE MEDICAID REIMBURSEMENT SO MORE PHYSICIANS WILL BE WILLING TO ACCEPT. TORT REFORM TO REDUCE COST OF MEDICAL CARE.

80 SET UP PUBLIC CLINICS STAFFED BY PRIVATE VOLUNTEER DOCTORS. THIS WOULD ENABLE PATIENTS TO HAVE ACCESS TO CARE AND DECREASE THE BURDENS ON THE PRACTITIONER TO PROVIDE INDIGENT CARE THROUGH PRIVATE OFFICES.

455 STATE OR FED FUNDED CLINICS STAFFED BY MD, NP OR PA TO TREAT MINOR ILLNESS, PROVIDE EDUC, & REFER OUT ONLY THOSE PTS WHOSE PROBLEMS ARE BEYOND THE SCOPE OF THEIR PRACTICE. CLINICS MIGHT ALSO HAVE MINIMAL GENERIC DRUGS ON HAND FOR THE POOR.

181 SUPPORT COMMUNITY HEALTH CENTERS

330 THERE IS NO FREE LUNCH. FREE BIRTHCONTROL FOR THE POOR (ETC.), EASY ACCESS. STATE OR FEDERAL MEDICAL CENTER FOR PATIENTS ON MEDICAID OR MEDICARE AND PAY THE DOCTOR'S MORE THAN CHICKEN FEED.

226 THESE ARE WORDS OF THE GOVT. GOVT SHOULD EITHER FURNISH NECESSARY CARE IN PUBLIC HLTH CLINICS OR CONTRACT DOCTORS WHO WILL FURNISH THE CARE (ALSO HOSPITALS,DENTISTS,PODIATRIST,ETC). THIS IS FUNDED BY INCOME &/OR SALES TAXES.

279 THEY CAN GET ACCESS THRU DEERING CLINIC.

121 EDUCATION-I HAVE AT TIMES OFFERED FREE CARE TO GROUPS WHO SERVICE INDIGENTS, TRANSIENTS, ETC. USUALLY WITH ALMOST ZERO ACCEPTANCE. I CANNOT EXPLAIN THIS, EXCEPT THAT "IF ITS FREE IT MUST NOT BE ANY GOOD."

136 FREE PUBLIC CLINICS MANNED BY NURSE PRAC.AND PHYS.PAID ADEQUATELY. CARE SHOULD BE LIMITED TO SIGNIFICANT ILLNESS,NOT TRIVIAL, AND TO PRE-NATAL & POSTNATAL CARE. ILLNESS PREVENTION, NUTRITIONAL PROBLEMS, AND PREGNANCY PREVENTION NEED TO BE EMPHASIZED.

60 APPROACH COULD BE TO IMPROVE THE REIMBURSEMENT IN PROGRAMS ALREADY IN PLACE & KEEP THESE SYS.FUNCTIONING THRU MEDICAL OFFICES-INCREASE IN REVENUES HELP. ENCOURAGES BETTER EFFORTS ON PART OF PRIVATE PHYS.FOR CHARITABLE CAUSES.

209 EXPAND PRIVATE HEALTH INS.COVERAGE, MANDATE HEALTH INS.COVERAGE PLUS COUNTY FUNDED CLINICS.

424 I WOULD NOT RECOMMEND FED OR STATE RUN MEDICAL CARE. PERSONALLY, WHEN THE FEDS BECOME TOTALLY INVOLVED, I WILL NOT PRACTICE MEDICINE. I WOULD RECOMMEND THAT INS COMP DECREASE THEIR PRICES FOR PROD & THAT INS. PAY FOR PREV. MED. STATE RUN CLINICS?

85 WOULD IT BE POSSIBLE TO SET UP A "FREE CLINIC" FOR INDIGENTS USING RETIRED MD'S TO MAN.IT? DECIDE WHO DOES OR DOESN'T NEED CARE. SEE SURVEY #85.

91 1) TAX BREAK FOR DRS FOR UNCOMPENSATED CARE(BAD DEBT DEDUCTIBLE) 2)CLINICS RUN BY DRS (VOLUNTEERS)BUT DRS THEN COULD NOT BE SUED FOR THEIR VOLUNTEER WORK.(IE IMMUNITY FROM LAWSUITS)

<u>EDUCATION/PREVENTION</u>

149 1)EDUCATION 2)ENCOURAGE PROVIDERS TO PROVIDE CARE, REGARDLESS OF ABILITY TO PAY. A CERTAIN % WILL ALWAYS BE CHARITY.

457 ABILITY TO PAY IS NOT THE PROBLEM. WE HAVE A WHOLE GENERATION OF PEOPLE WHO ARE IRRESPONSIBLE, DON'T KNOW HOW TO ACCESS JOBS, MEDICAL CARE, PERSONAL RELATIONSHIPS, ETC. THEY NEED GENERAL EDUCATION & I DOUBT THIS WILL MAKE ANY DIFFERENCE.

439 ACCESS TO FED/STATE PROG SHOULD BE LIMITED IN THE DURATION OF TIME THAT THESE PEOPLE REQUIRE ASSISTANCE. NEED A CASE WORKER TO HELP REHABILITATE & HELP PEOPLE HELP THEMSELVES. MT IS TOO GENEROUS WITH OUT OF STATE PATIENTS. GET MEDICAID TO EASILY.

133 EDUCATE THE PT. I'LL SEE ANYONE NO MATTER WHAT. I DO APPRECIATE IT IF THEY TELL ME THEY CAN'T PAY.

266 EDUCATE THEM IN PREVENTIVE MEDICINE & SHOW THEM HOW TO INCREASE INCOME & BUDGET RESOURCES SO THEY CAN AFFORD TO PAY FOR CARE OR OBTAIN INSURANCE. (INSURANCE COS.-ALLOW THEM TO PROVIDE WIDER ACCESS TO THEIR PROGRAMS.

333 EDUCATION IN SCHOOLS AS TO THE IMPORTANCE OF HEALTH CARE INSURANCE AND WHAT IS AVAILABLE IF PERSON CANNOT AFFORD IT

433 EDUCATION OF SOCIETY TO KEEP AFTER THE STIGMA AS PERCEIVED BY THOSE THAT CANNOT PAY. MOST PHYSICIANS WILL PROVIDE CARE IF THE POOR WILL ARRANGE TO BE SEEN FOR CARE.

445 EDUCATION TO EXPLAIN AVENUES OF ACCESS TO SYSTEM. GET RID OF MEDICAL SUBSIDIES WHICH PARADOXICALLY LEAD TO ABUSE, POOR CARE, GENERAL LACK OF RESPON. REQUIRE INSURERS AUDIT THEIR PAY-OUTS REVIEW CARE IN TERMS OF REASONABLE GOALS OR END POINTS.

97 ENCOURAGE COHESION, STABILITY OF FAMILIES, DISCOURAGE FAMILY BREAKUP.

67 I WOULD LIKE TO SEE A CONTRIBUTORY PLAN TO HELP THE WORKING POOR BETTER ACCESS TO LOW COST MEDICINE. NEED TO AVOID ER OR EMERGENCY CARE SITUATIONS.

37 INCREASE ADVICE ABOUT NOT SMOKING. MANY CAN'T AFFORD BECAUSE OF WHAT THEY SPEND ON TOBACCO.

261 INCREASE HLTH DEPT.COVERAGE TO INCLUDE AN MD AS A "GATEKEEPER" TO STATE MEDICAID/CARE. INCREASE FUNDING FOR PREVENTIVE MEASURES, IE WELL BABY, IMMUNIZATION PROGRAMS, TEACHING IN SCHOOLS AND UNIVERSITIES.

337 MORE EDUCATION NEEDED. APPROPRIATE UTILIZATION WOULD ALSO HELP STRETCH THE RESOURCE. ACCESS TO CURRENT CARE SYSTEM IS NOT UNDERSTOOD.

480 PREVENTIVE MEDICINE MONEY IS MORE WISELY SPENT MONEY THAN ACUTE CARE MONEY.

238 PRIORITIZE NEEDS-CHILDREN AND PREVENTATIVE CARE ARE MUCH MORE COST EFFECTIVE PRIORITIES.

10 PROVIDE COVERAGE FOR WELL CHILD CARE (INCLUDING COVERAGE BY INSURANCE).

285 PROVIDE PREVENTIVE AND HLTH MAINTENANCE VISITS THROUGH COUNTY PROGRAMS.

339 WE ACCEPT SMALL MONTHLY PAYMENTS. MEDICAID PATIENTS ABUSE PRESCRIPTIONS - HAVE THEM PAY MORE FOR MEDICINE AND MEDICAL CARE. ENCOURAGE EVERYONE TO GET INSURANCE WITH DEDUCTIBLE. EDUCATION TO HAVE SOME COVERAGE.

301 WOULD LIKE COOPERATIVE EFFORT BETWN PRIVATE PROVIDERS & PUBLIC HLTH PROGRAMS TO CARE FOR POP.W/OUT MEANS TO PAY.(CRITICAL FOR PREGNANT WOMEN & CHILDREN)-THIS IS A INVESTMENT IN PREVENTION-SAVE $ DOWN THE ROAD. SEE SURVEY # 301.

94 TAX INCENTIVE OR COMPENSATION TO PROVIDERS FOR LOSSES RELATED TO INDIGENT CARE. INCENTIVE TO PROMOTE HLTH MAINTENANCE WITHIN THE EXISTING FRAMEWORK OF PROVIDERS.

PHYSICIAN MANDATE

475 TREAT AND FIGURE OUT HOW TO PAY LATER.

468 RURAL VS URBAN INEQUITIES IN HOSPITAL PROVIDER PAYMENTS SHOULD BE REMEDIED. HONESTY ABOUT FINANCIAL STATUS IN SPEAKING TO PHYSICIANS.

466 INSTITUTE LOCAL PROGRAMS TO IDENTIFY TRULY NEEDY & PHYSICIANS THEMSELF DISCOUNT OR GIVE FREE CARE WITHOUT GOVT INTERFERENCE.

110 IDENTIFY THEM MORE ACCURATELY WHEN WE SEE THEM

437 IF PATIENT CANNOT GET AN APPOINTMENT FOR FINANCIAL INABILITY, ASK THEM TO TALK WITH THE DOCTOR AND PUSH THROUGH THE OFFICE STAFF TO A PERSONAL APPOINTMENT WITH THE DOCTOR TO DISCUSS RECEIVING CARE.

284 GET THE MEDICAL PROFESSION TO DO IT INSTEAD OF THE GOVT (I'M AFRAID THAT'S TOO LATE NOW)

378 FRANK DISCUSSION WITH THEIR PHYSICIAN WHO CAN WITH THEIR STAFF WORK OUT SOCIAL SERVICES & SUPPORT WITHIN THE COMMUNITY. A GATE KEEPER SYSTEM.

498 APPROACH THEIR OWN M.D. RE:ABILITY TO PAY AND OPTIONS THEY PERSONALLY WOULD OFFER.

108 BE HONEST. IF SOMEONE TELLS ME UP FRONT OF THEIR FINANCIAL PLIGHT-I DO A FREEBIE-NO PROBLEM.

14 ALL PHYSICIANS NEED TO ACCEPT A SHARE IN THE CARE OF MEDICALLY INDIGENT PATIENTS. THE GOVERNMENT NEEDS TO RECOGNIZE THAT PHYSICIANS WILL NOT TOLERATE THE BURDEN FOR INDIGENT PATIENTS BEYOND A CERTAIN POINT AND NOT OVER TAX THEIR GENEROSITY.

347 ALL PHYSICIANS SHOULD BE REQUIRED TO ACCEPT NEW MEDICARE/MEDICAID PATIENTS; BUT MANDATORY ASSIGNMENT WILL DECREASE ACCESS (DELAYED APPOINTMENTS AND REFERRAL TO E.R. FACILITIES)

26 ALLOCATE PATIENTS EQUALLY AMONG ALL PHYS. WHO CAN'T PAY.

463 DOCUMENT INABILITY TO PAY. PLAN ON DOING A CERTAIN % OF CHARITY CARE. DO THIS BY STAFFING CHARITY CLINICS RUN BY HOSPITALS. EVERY PHYSICIAN HAS TO HELP SO A FEW ARE NOT DUMPED ON & FORCED OUT OF BUSINESS. IT SHOULD BE CRITERIA FOR STAFF PRIVILEGES.

195 ENCOURAGE ALL HLTH CARE PROVIDERS TO SHARE THE "BURDEN"-IE. HOSPITAL PRIVILEGES BASED ON PROOF OF WILLINGNESS TO SEE MEDICAID, UNINSURED ETC.

375 FAIR COMPENSATION TO PHYSICIANS FORCING THEM TO GIVE FREE CARE WILL INEVITABLY LEAD TO RESENTMENT WITH SUBSTANDARD CARE.

412 I ALWAYS CARED FOR ITEM MYSELF.

499 I DON'T KNOW THE ANSWER. I WOULD RATHER DO CHARITY HOWEVER THAN MAKING AN INCREASING NUMBER OF AMERICANS DEPENDENT ON THE GOVERNMENT AND THEREBY LESS ABLE AND WILLING TO ASSUME RESPONSIBILITY FOR THEMSELVES.

27 IF THEY CALL MY OFFICE, I WILL ALWAYS SEE THEM AND GIVE THEM THE SAME LEVEL OF CARE AS ANYONE ELSE. (THEY JUST NEED TO SAY THAT THEY CAN'T PAY SO THEY WON'T GET BILLED)

88 INITIATE SYSTEM TO INSURE THAT ALL PHYSICIANS SHARE EQUALLY IN THE BURDEN OF CARING FOR THESE PATIENTS.

56 LEGISLATE THAT ALL PHYSICIANS BE FORCED TO SEE THESE PATIENTS (IE EQUAL ACCESS LEGISLATION). MOST PHYSICIANS DO NOT SEEM ABLE TO RECOGNIZE THEIR MORAL OBLIGATIONS TO BE FAIR TO ALL.

49 MAGNITUDE OF ? IS ENORMOUS."EVERYONE" DEMANDS "QUALITY" CARE,YET MEDICINE IN GENERAL HAS BEEN TARGETED TO PROVIDE THIS AT LESS COST.BUSINESSES ARE FREE TO FLUCTUATE AS THE MARKET ALLOWS. I PROVIDE CARE REGARDLESS OF ABILITY TO PAY. SEE SURVEY #49.

154 PHYSICIANS SHOULD BE WILLING TO GIVE CHARITY CARE & DEVISE MEANS OF DECREASING COSTS TO PTS (FEWER TESTS, SHORTER HOSPITALIZATIONS, ETC.Z)

287 PUBLICIZE THAT MOST PHYS.ARE WILLING TO CARE FOR PEOPLE REGARDLESS OF ABILITY TO PAY.

349 SPREAD THEM FAIRLY AROUND MEDICAL COMMUNITY.

11 SUSPECT FEDERAL LEGISLATION THE ONLY WAY, BUT SHOULD MAKE LICENSURE CONTINGENT ON UNRESTRICTED ACCESS (I.E. DOCTORS SHOULD NOT BE ALLOWED TO HAVE A "NO MEDICAID POLICY")

341 THERE IS ALWAYS GOING TO BE THOSE PEOPLE THAT FALL THROUGH WHAT EVER PROGRAMS. I BELIEVE IT IS THE RESPONSIBILITY OF ALL PHYSICIANS TO PROVIDE A CERTAIN PERCENTAGE OF THEIR PRACTICE FOR CARING FOR THOSE PEOPLE.LAST YEAR WE WROTE OFF $80,000 FREE CARE.

428 THIS PHYSICIAN TREATED ALL HIS NEEDY PATIENTS FREE FROM 1961 ON UNTIL THIS YEAR WHEN HE SERVED AS LOCUM TENENS UNDER CONTRACT FOR A SHORT TIME. HE NEVER SENT BILLS UNLESS REQUESTED. THIS PHYSICIAN HAS PRACTICED FOR 47 YEARS.

291 UNIVERSAL MEDICAL CARE-CANADIAN MODEL.

89 EXPAND MEDICAID ELIGIBILITY & INCREASE MEDICAID REIMBURSE SO PHYS.DO NOT TAKE SUCH AS FINANCIAL LOSS TREATING MEDICAID PTS. I TREAT MEDICAID PATIENTS BECAUSE OTHER PHYS.FREQ. REFUSE TO, BUT DUE TO THE FINAN.STRAIN & LO REIM., I MAY LIMIT THE #.

425 A BETTER DISTRIBUTION OF PHYSICIANS WOULD HELP CURRENTLY IN UNDERSERVED AREAS. THE POOR ARE UNABLE TO DRIVE TO WHERE CARE IS AVAIL. DENY HOSPITAL PRIV TO ANY PHYSICIAN WHO REFUSES TO ACCEPT MEDICAID PTS. TAX BREAK FOR THOSE DOING UNCOMP CARE.

<u>REVISE INSURANCE</u>

484 REQUIRE HEALTH INSURANCE TO ATTEND COLLEGE OR UNIVERSITY IN MONTANA.

447 REQUIRE INSURANCE WITH ALL JOBS, ESPECIALLY LARGE RETAIL COMPANIES WHO TAKE ADVANTAGE OF PART TIME EMPLOYERS.

118 MIDDLE INCOME GROUPS W/CATASTROPHIC MEDICAL PROBLEMS-CANCER FOR EXAMPLE OFFER THOSE THE ABILITY TO CONTINUE NORMAL PREMIUM HLTH INS. THEY EITHER DROP COVERAGE BECAUSE OF THE MASSIVE INCREASE IN SUBSEQUENT PREMIUMS OR SUBJECTED TO FINAN. HARDSHIPS.

389 HAVING SENSIBLE AFFORDABLE INSURANCE THAT COVERS WELL CHILD VISITS, INCLUDING IMMUNIZATIONS. THERE IS RARE NEED FOR HOSPITALIZATION OF PEDIATRIC PATIENTS, AT $250/DAY. THIS KIND OF COVERAGE PREVENTS PREMIUM PAYERS FROM GETTING THEIR MONEYS WORTH.

348 HEALTH INSURANCE SUBSIDIES FOR WORKING POOR.

111 GROUP ST.INS.COVERAGE IS AN OPTION TO EXPLORE. PERSONS ENTER THE JOB MARKET THEY PAY SMALL INS.PREM. SURCHARGE MATCHED BY EMPLOYERS FOR 5 YRS TO BE USE AS ASSISTANCE FOR UNEMPLOYED BUT EMPLOYABLE WORKERS. SEE SURVEY #111.

479 DEVELOP A SYSTEM OF MANDATORY HEALTH INS THROUGH A PAYROLL DEDUCTION PROG. THE AMOUNT BASED ON INDUSTRY DATA, VARYING THE DEDUCTION ACCORDING TO UTILIZATION. A FREE COVERAGE SYSTEM IS UNWORKABLE AND EXPENSIVE.

368 EMPLOYERS HAVE GOT TO CONTRIBUTE INSURANCE TO PART TIME JOBS. MAKE INSURANCE AVAILABLE TO ALL BY STATE PROGRAM OR STATE LAW REGULATING PRIVATE COMPANIES. TOO MANY TURNED DOWN BECAUSE THEY HAVE A PROBLEM.

LIABILITY/TORT REFORM

50 1)REDUCE HOSP.COSTS BY REDUCING ADMIN.,EXPENSIVE &EXCESS BUILDING PROGRAMS W/PROFIT MOTIVES & REDUCE FED.OR ST. REGULATIONS THAT INCREASE HOSP.COSTS. 2)HELP PHYS.BY CONTROLLING MALPRAC.RISKS. 3)PHILOSOPHY OF TREATING PT EQUAL REGARD.OF ABILITY TO PAY.

343 COMPREHENSIVE SOLUTION TO LIABILITY CRISIS-GROSSLY UNFAIR TO EXPECT PRACTITIONERS TO RISK LIABILITY EXPOSURE FOR CHARITABLE CARE. COMPLETE OVERHEAD OF MEDICAID - PRICING, ELIGIBILITY, ETC.

373 INSTITUTE A RELATIVE VALUE SCALE & TAKE SOME OF THE MONEY USED FOR OVERPRICED SPECIALTY PROCEDURES & REIMBURSE PRIMARY CARE SERVICES BETTER. ENACT LEGISLATION TO CONTROL MALPRACTICE PREMIUMS WHICH MAKES IT HARD TO AFFORD TO PRACTICE OB.

44 MANDATORY DEDUCTIONS FORM SALARY TO PAY FOR HLTH INS. MANY PHYS.ARE UNWILLING TO SEE PT ON MEDICAID BECAUSE THE REIMBURSEMENT IS NOT SUFFICIENT TO COVER THEIR EXPENSES & THE THREAT OF LAWSUITS. TORT REFORM WOULD PROTECT PHYS.FROM SUITS. SEE SURVEY 44.

406 MUST CONTAIN MORE ADEQUATELY NON-PROVIDER EXPENSES THUS FREEING UP MORE MONIES FOR PATIENT CARE. IMPROVE CURRENT MEDICAL-LEGAL ATMOSPHERE, THUS REDUCING LARGE NUMBER UNNECESSARY TESTS, ETC.

370 PROVIDE MALPRACTICE INSURANCE FOR RETIRED MD'S. THEREBY ENABLING THEM TO WORK ON OP BASIS AT FREE CLINICS. HAVE LEGAL PROFESSION PROVIDE PRO BONO COVERAGE FOR DOCTORS TREATING INDIGENT.

25 REDUCED LIAB.(THEREFORE INS.COSTS)FOR PRACTITIONER. A MEANS TO IDENTIFY THESE INDIVIDUALS MAY BE UNPALATABLE TO SOME, BUT IS ALMOST A PREREQUISITE TO AVOID UNNECESSARY BILLING EXPENSE.

408 THIS IS TAKEN CARE OF IN OUR COMMUNITY (FREE STANDING CLINIC - PAY AS ABLE TO PAY).

358 WE NEED NATIONAL LEADERSHIP TO SET UP A UNIFORM SYSTEM OF HEALTH CARE FOR ALL OF US. THIS MUST ADDRESS THE MALPRACTICE PROBLEM AND ALSO LOOK TO WAYS TO IMPROVE THE EFFICIENCY OF OUR SYSTEM.

267 REVAMP 1)OVERALL MED.CARE SYS. 2)MEDICAL LIAB. 3)SOCIETY'S EXPECTATIONS OF MED.CARE. PIECEMEAL APPROACH TO PROBLEMS ARE NOT GOING TO WORK. I DON'T THINK ASKING PHYS.TO DO EVERYTHING IS FAIR OR WILL WORK. WRITE OFF $12000-15000/YR. OF FEES ALREADY.

421 SOCIETY NEEDS TO DECIDE WHAT IT WANTS TO PAY FOR. WE NEED TO MAKE DECISIONS ABOUT NEW TECHNOLOGIES & TREATMENTS THAT ARE SO EXPENSIVE AS A GOVT. OR SOCIETY RATHER THAN IN THE DR.'S OFFICE. CURBING MALPRAC.INS. RATES WOULD MAKE OB CARE MORE AVAILABLE.

210 RETURN TO MORE TRUE CHARITY CARE AND ENCOURAGE PROVIDERS TO DO SO BY INCENTIVES SUCH AS REDUCTION IN LIABILITY PARTICULARLY IN THOSE CASES.

MEDICAID/MEDICARE

169 1)EXPAND MEDICAID/MEDICARE COVERAGE FOR PTS. 2)INSURE THAT ALL PROVIDERS SHARE THE RESPONSIBILITY TO CARE FOR THOSE UNABLE TO PAY.

313 A MORE REALISTIC REIMBURSEMENT FOR MD'S WILLING TO SEE MEDICAID PATIENTS. A REDUCTION IN MALPRACTICE PREMIUMS TO HELP OFFSET PROVIDING UNCOMPENSATED SERVICES.

304 ACCESS IS A PROBLEM. OUR OB PRACTICE IS 60% MEDICAID WHEN IT SHOULD BE 30-35%. INCREASING MEDICAID PAYMENTS WILL MORE FAIRLY DISTRIBUTE ACCESS & INCR.ACCESS IN RURAL AREAS. BETTER TORT REFORMS & PREMIUMS-ALLOW PHYS.TO PROVIDE CARE NOW ABANDONING.

393 CLEAN UP FRAUD IN PRESENT SYSTEM. SO MUCH ABUSE OF MEDICAID BY PEOPLE ABLE TO BUT TOO LAZY TO WORK AND PROVIDE FOR THEMSELVES.

264 DECREASE MALPRACTICE INS.(REASON FOR INCREASING PRICES)-NEED TO GET INTO LEGAL SYS. & CHANGE MODE OF REIMBUR.-NOT HAVE LAWYERS GET % OF SETTLEMENT. I DO MUCH MORE TESTS ON PEOPLE THAN IS NECESSARY JUST TO CMA.

39 DISCARD MEDICARE & MEDICAID.NOT EVERYONE OVER 65 IS IN NEED OF ASSISTANCE AND DOESN'T ENTITLE THEM TO SUCH.IMPROVE REIMBURSEMENT FOR THOSE WHO CAN NOT AFFORD HLTH CARE.ELIMINATE LOOPHOLES & SIMPLIFY REGISTRATION PROCESS.GREATER CARE FOR THOSE WHO TRY.

128 DON'T CUT MEDICARE/MEDICAID.

8 ELIMINATE MEDICAID PROGRAM-MOST OF MONEY GOES TO ADMINISTER THE PROGRAM RATHER THAN TO HLTH CARE PROVIDERS. HAVE DOCTORS SEE MEDICAID PTS AT NO CHARGE. HALF DAY PER WEEK-IN RETURN, THE MD GETS A STATE TAX CREDIT FOR PROVIDING THE SERVICE(LOOK@SURVEY).

286 EXPAND MEDICAID.

78 EXPAND MEDICAID ELIGIBILITY AND BENEFITS.

491 EXPAND MEDICAID OR SIMILAR TYPE OF INSURANCE PLAN TO ADEQUATELY COVER NEEDS AND PATIENTS.

19 EXPAND MEDICAID TO THOSE PERSONS.

448 EXPANSION OF MEDICAID RATHER THAN THE CURRENT RESTRICTION (IN MENTAL HEALTH ACCESS). THE MANAGEMENT GROUP FOR PSYCH-SERVICES FOR MT MEDICAID WILL ONLY DRIVE MORE MD'S FROM PROVIDING CARE (WHICH MAY BE WHAT MT MEDICAID WANTS).

443 FEDERALLY MANDATED INS PROG FOR ALL. TORT REFORM WOULD MAKE ACCESS TO OB CARE BETTER AS MANY WILL NOT DO OB NOW DUE TO HIGH COST OF LIABILITY INS. OB CARE NEEDS TO BE PAID BETTER. LOW REIMBURSEMENT FROM MEDICAID MAKES OB STOP ACCEPTING NEW MED PTS.

331 FOLLOW THE GUIDELINES AND GET ON MEDICAID. ENCOURAGE MEDICAID TO KEEP UP ADEQUATE PAYMENT SCHEDULE.

62 FORGET MEDICARE AND MEDICAID. GO BACK TO THE PAY AS YOU GO OR ASSISTANCE FOR THOSE WHO CAN'T THROUGH A LOCAL AGENCY AND BACK TO FREE CARE FOR THE INDIGENT WORKING CLASS.

34 GOVT OVERSEES PROGRAMS HAVE NEVER SAVED A PENNY-ESPECIALLY WHEN COSTS OF ADMINISTRATION ARE FACTORED IN. GOVT PURCHASE OF EFFECTIVE PRIVATE 3RD PARTY COVERAGE WOULD BE CHEAPER AND BETTER FOR ALL. LOOK AT SURVEY 33.

147 I'M UNINFORMED AS TO HOW TO HELP THEM. HIGHER MEDICAID & MEDICARE PMTS WOULD ALLOW ME TO SEE MORE POOR PTS AT NO CHG.OR A REDUCED FEE, BUT 50-60% REIMBUR.IN MEDICAID MAKES IT NECESSARY TO LIMIT MY PRACTICE TO 15% OF EACH MEDICARE/MEDICAID POPULATION.

305 IF PHYSICIANS WERE ADEQUATELY PAID BY MEDICARE/MEDICAID THEY WOULD BE MORE WILLING TO PROVIDE SERVICES-PHYS. CAN NOT CONTINUE BEING REIMBURSED LESS THAN THEIR COSTS.

229 IMPROVED ACCESS TO PUBLIC ASSISTANCE AND MORE REASONABLE REIMBURSEMENT SCHEDULE FOR THOSE PTS ON PUBLIC ASSISTANCE. IF THE LATTER DOES NOT OCCUR, THERE WILL ALWAYS BE DIFFICULTY ACCESSING QUALITY CARE.

20 IMPROVING REIMBURSEMENT FOR PHYSICIANS WORKING IN RURAL AREAS SUCH THAT PRACTICING IN RURAL AREAS BECOMES ATTRACTIVE.

258 INADEQUATE FUNDING FOR PHYS.SERVICES BY MEDICARE/MEDICAID MAKE IT MORE DIFFICULT TO CARE FOR PTS W/THESE COVERAGES. EXPENSES (FIGURED PROPORTIONAL TO TIME SPENT W/PT) HAVE LITERALLY OUTSTRIPPED WHAT IS PAID FOR THE TIME.

354 INCREASE ACCESS AND REIMBURSEMENT FOR PREVENTIVE CARE.

271 INCREASE COVERAGE FOR PSYCHIATRIC PROVIDERS. DE-STIGMATIZE PSYCHIATRIC TREATMENT THROUGH EDUCATION.

233 INCREASE ELIGIBILITY.

394 INCREASE MEDICAID PAYMENTS TO AT LEAST 80% OF UCR. PASS CHIRP. STATE INSURANCE PLAN FOR ALL CHILDREN AND PREGNANT WOMEN.

442 INCREASE PAYMENT SCHEDULE FOR ME TO POOR OR NEAR POOR. PRIVATE PAY/PRIVATE INS TO AVOID HIDDEN TAX TO WORKING INSURED WHO SUBSIDIZES BOTH NONPAY PTS & MEDICAID PTS DUE TO SUB PAR (DISCOUNTED) PAYMENT SCHEDULES MANDATED BY MEDICAID.

431 INVOLVEMENT OF GOVERNMENT IN THE GROUPS OF PEOPLE BETWEEN MEDICAID AND MEDICARE AND THE WORKING POOR.

151 LIMIT THEIR ACCESS TO CARE-MANY OF THESE PEOPLE ABUSE THEIR UNLIMITED ACCESS TO MEDICAL CARE.(MEDICAID).

204 LIMIT USE OF EMERGENCY ROOM SERVICES. HIGHER REIMBURSEMENT FOR FAMILY PRACTICE MD AND DECREASE REIMBURSEMENT FOR SURGEONS, RADIOLOGIST, ETC. (WHO ARE FREQUENTLY OVERIMBURSED FOR SERVICES).

362 MAKE GOVERNMENT PAYMENTS CLOSE TO NORMAL AVERAGE FEES. BUT CONTROL UNNECESSARY VISITS BY PATIENTS WHO DO NOT PAY, TO ABUSE THE AVAILABLE SERVICES.

18 MAKE PMTS FULL ON PRESENTLY UNINSURED INDIVIDUALS. IF MEDICARE WOULD PAY WHAT IS CHARGED, THEN THERE IS MORE CAPITAL TO WORK WITH AND CAN ABSORB MORE NON-PAYING CASES. OFFERING ANOTHER INADEQUATE PMT SYSTEM DOES NOT SOLVE THE PROB.IT COMPLICATES IT.

481 MANDATORY INSURANCE FOR EMPLOYEES PAID FOR BY EMPLOYEES. BROADEN MEDICARE/MEDICAID INCLUSIONS.

460 MEDICAID & MEDICARE MUST START REIMBURSING AT A RATE WHICH WILL COVER THE EXPENSES FOR THE SERVICES RENDERED. NOW I CHARGE THOSE WITH PRIVATE INS MORE TO COVER COSTS. THIS IS GROSSLY UNFAIR TO THE WORKING TAXPAYER. GOVT REG. ARE FORCING ME TO RETIRE.

444 MEDICAID IS A TOTAL FAILURE. IT COSTS ME MORE TO BILL MEDICARE THAN TO JUST DELIVER FREE CARE. CONSEQUENTLY I DO NOT DO MEDICARE.

430 MEDICAID REIMBURSEMENT DON'T COVER OVERHEAD. IF THESE WERE RAISED & MORE OF THE PRESENTLY UNINSURED QUALIFIED WE COULD COVER THEM EASILY. BOTH MEDICAID & ESPEC MEDICARE HAVE CREATED A QUAGMIRE OF PAPERWORK & RISK FOR PHYSICIANS. HARD TO ACCEPT PTS.

427 MEDICARE/MEDICAID SHOULD PAY GREATER PERCENTAGE OF CHARGES. I WOULD BE MORE WILLING TO SEE NEW MEDICARE/MEDICAID PATIENTS IF I WASN'T LOSING MONEY ON EACH VISIT.

411 PAYMENT PROPORTIONED TO CARE GIVEN - BETTER REIMBURSEMENT FOR TRAUMA CARE. MORE LIMITS ON ELECTIVE SURGERY FOR MEDICAID PATIENTS.

363 PROVIDE HEALTH CARE FOR THOSE WORKING. DENY TRIVIAL, NON-EMERGENT CARE IN E.R. FOR PATIENTS BENEFIT AT A COST 3-5 TIMES HIGHER. MAKE MEDICAID REIMBURSEMENT MORE FAIR. BETTER EDUCATIONAL PROGRAMS FOR HEALTH CARE - MANDATORY ATTENDANCE.

164 REDUCE PAYMENT/BENEFITS FOR THOSE CURRENTLY RECEIVING.

170 REIMBURSEMENT THROUGH STATE/FEDERAL PROGRAMS MUST BE INCREASED TO MORE THAN COVER OVERHEAD EXPENSES.

483 REVOKE MEDICARE/MEDICAID ALLOW PHYSICIANS TO DONATE TIME FOR CHARITABLE CARE - MANDATE IT IF YOU WISH.

432 SAFETY NET FOR THOSE UNABLE TO PAY. EXPAND MEDICAID COVERAGE TO 150-175% POVERTY LEVEL, BUT INSTALL STRICT GUIDELINES & MECHANISMS TO INSURE APPROP UTILIZATION BY DR & PTS. TOO MANY MEDICAID ABUSERS.

462 SOME WAY TO STOP OVER-UTILIZATION & ABUSE BY SOME OF MEDICAID RECIPIENTS & WITH SAVINGS HELP COVER THOSE WHOSE INCOME IS INADEQUATE TO COVER HEALTH CARE BUT DON'T QUALIFY FOR GOVT AIDE.

114 STATE FUNDED CLINICS IN URBAN AREAS-WIDER ELIGIBILITY AND COVERAGE BY MEDICAID .

52 STRAIGHTEN OUT MEDICAID.

298 THE BEST RECOMMENDATION I HAVE IS DON'T BELITTLE THEM. THE MEDICAID SYSTEM AND APPLICATION PROCESS CAN BE DIFFICULT AND VERY DEGRADING.

212 TOO ACCESSIBLE NOW-90% ABUSE IT ONCE THEY ARE ON IT. ONE CHILD GETS SICK-MOM THINKS ALL OTHER KIDS NEED CHECKING TOO. SEE LESS OF THEM ONCE THEY GET A JOB(FEW DO)& GET OFF MEDICAID. THE ELIGIBILITY REQUIREMENTS NEED TO BE TIGHTENED UP.

9 1)IMPROVE MEDICAID REIMBURSEMENTS 2)BROADEN MEDICAID & MEDICARE ELIGIBILITY 3)MANDATORY HLTH INSURANCE 4)STIFF TOBACCO & ALCOHOL TAXES-PROCEEDS TO MEDICAID FUNDING 5)REDUCE "HASSLE FACTOR" IN MEDICAID/MEDICARE ADMINISTRATION.

40 MORE MEDICAID IS NOT THE ANSWER. I STILL LOSE MONEY ON MEDICAID. I WOULD RATHER TREAT SOMEONE WITH NO INSURANCE. WE NEED EQUAL ACCESS TO MEDICAL CARE FOR EVERYONE. THIS MAY BE A NATIONAL HLTH INSURANCE.

158 SOME SORT OF UNIVERSAL HTLH INS., PREFERABLY NOT GOVT RUN. BETTER EDUCATION FOR UTILIZATION OF PREVENTATIVE HLTH CARE, USE OF EXISTING SERVICES, GETTING PRENATAL CARE. BETTER MEDICAID PMTS SO ALL PHYS. WILL SEE THOSE PTS.

138 ENTITLEMENT PROGRAMS(MEDICARE & THE VA) GIVE TOO MUCH TO PEOPLE WHO CAN AFFORD SOME OF OWN CARE. THESE PROGRAMS DEPRIVE NEEDY PEOPLE OF ACCESS TO CARE. MEDICAID WAS SUPPOSED TO ALLEVIATE PROBLEM, BUT WILL NOT UNTIL PHYS.ARE PAID MORE BY THE PROGRAM.

426 MT'S FOR WHOM I CARE HAVE IT MADE. MEDICAID PTS RECEIVE THE SAME TAX AS PRIVATE PAY PTS. I SUBSIDIZE THE REIMBURSEMENT VIA MY TAXES, & AM REIMBURSED AT SUCH A LOW LEVEL AS TO LOSE MONEY ON THESE VISITS. NATIVE AMER. ABUSE BOTH PROGRAMS IHS & MEDICAID.

92 M/C & M/C WILL HAVE TO BE REMOVED. THE INDIANS ALREADY HAVE GOOD, FREE MEDICAL CARE & THEY'LL ABUSE PLAN THAT ALLOWS THEM TO GO ANYWHERE FOR MED.CARE. MEDICAL CARE SHOULD BE PRIORITIZED SO THAT NON EMERGENT VISITS TO ER'S SHOULD HAVE TO PAY. SURVEY #92.

273 1)LIMIT MED.LIAB.TO MD 2)SERVICES RENDERED TO PERSON UNABLE TO PAY BE A TAX DEDUCTION FOR PROVIDER 3)MAKE MEDICARE/MEDICAID PAY PROPER AMOUNT NOT THE 40-60% DISCOUNT. 4)ELIMINATE HMO'S & PPO'S-LEADS TO INCREASED RATES FOR THOSE NOT IN HMO OR PPO.

7 1)PROVIDE TAX INCENTIVES TO EMPLOYERS SO AS TO PROVIDE INSURANCE. 2)LEGISLATE AN "ASSIGNED RISK POOL" @ GOVT EXPENSE. 3)REDUCE THE SIZE OF STATE GOVT AND MEDICAID BUREAUCRACIES. 4)ELIMINATE MEDICAID/MEDICARE BUREAUCRACY EVENTUALLY AFTER TRIAL OF #2.

367 ALLOW CURRENT MEDICARE RECIPIENTS TO PURCHASE PRIVATE INSURANCE IF THEY SO WISH. THIS WOULD FREE UP MORE MEDICARE MONEY FOR THOSE WHO REALLY NEED IT. OFFER BUSINESSES A TAX ADVANTAGE OF SUPPLYING HEALTH INSURANCE TO ITS EMPLOYEES.

327 ALLOW REASONABLE REIMBURSEMENT INCLUDING UNRESTRICTED BALANCE BILLING OF FINANCING WELL OFF MEDICARE PATIENTS. REMOVE THE MEDICAID STIGMA. IT WOULD BE EASIER TO SEE THEIR PATIENTS FOR FREE & TAKE A TAX WRITE OFF OR TAX CREDIT FOR DOING IT.

372 BY DECREASING THE NUMBER OF PERSONS IN THIS GROUP I.E. INCENTIVES FOR EMPLOYER BASED INSURANCE AND INCENTIVE FOR PROVIDERS TO DELIVER MORE UNCOMPENSATED CARE. MEDICARE REFORM WITH A MEAN TEST OF BENEFITS WOULD ENCOURAGE PROVIDERS TO DELIVER CARE.

488 INCREASING REIMBURSEMENT TO THOSE PROVIDING THE CARE TO A MORE REASONABLE LEVEL. ENCOURAGING SUBSIDIZED INS FOR WORKING POOR. ALLOWING DR'S TO TAX DEDUCT BAD DEBTS SUCH AS UNCOMPENSATED CARE.

146 LOWER MEDICAID THRESHOLD. RECOGNIZE UNCOMPENSATED CARE- IN FORM OF TAX CREDITS.

98 TAX INCENTIVES TO THOSE WHO CARE FOR THEM. FAIR PAY FOR MEDICARE AND MEDICAID PTS WOULD ALLOW MORE ROOM IN OVERHEAD STRUCTURE FOR INDIGENT CHARITY CARE.

<u>NATIONAL HEALTH INSURANCE</u>

122 MOST COMPREHENSIVE APPROACH? WE NEED NAT'L HLTH INS.ON THE CANADIAN MODEL. THIS COULD BE ACHIEVED ON A ST.LEVEL. CONSIDER RATIONING SERVICES AS OREGON IS DOING AND DECREASING THE REIMBUR.TO OVERPAID SPECIALISTS,SO MORE PRIMARY CARE CAN BE PROVIDED.

140 PROBABLY NEED SOCIALIZED HLTH CARE SYS.-PERHAPS ON CANADIAN MODEL-HLTH CARE SYS.NEEDS MAJOR OVERHAUL.

401 THE USA NEEDS A NATIONAL HEALTH INSURANCE PLAN (CANADIAN).

377 CARE FOR ALL REGARDLESS OF ABILITY TO PAY. LIMITS ON THE OBSCENE PROFITS OF DOCTORS. MAKING PATIENTS RESPONSIBLE FOR THEIR HEALTH CARE. RATIONING HEALTH CARE. EDUCATION TO TEACH PEOPLE HOW TO CARE FOR THEMSELVES.

259 STATE AND FEDERAL REIMBURSEMENT PROGRAMS. VIA OPTIONAL INSURANCE OR RELIEF COVERAGE.

225 STATE OF FEDERAL GOVERNMENT NEEDS TO GET INVOLVED TO HELP PAY FOR THEIR MEDICAL CARE.

207 1)NATIONAL HLTH CARE 2)PAY MED SCHOOL FOR PUBLIC SERVICE IN HLTH CAR CLINICS. 3)WITHDRAW HLTHCARE-LET PEOPLE DIE NATURAL DEATHS 4)LIMIT HLTH CARE FOR CHRONIC MEDICAL PROBLEMS WHEN SELF INDUCED (ALCOHOL, SMOKING) PRIVILEGE NOT A RIGHT.

117 1)SOME SORT OF NATIONAL INS. PLAN 2)MORE PHYS. WILLING TO REDUCE FEES FOR LOW INCOME PATIENTS.

417 A MODIFIED TYPE OF NATIONAL OR STATE HEALTH INSURANCE (APPROPRIATE FOR STATUS OF EMERGENCY, NON-EMERGENCY, ETC.)

360 A NATIONAL HEALTH PLAN. GENERIC MEDICATIONS. CONTROL REFERRALS TO SPECIALISTS AND SURGEONS THROUGH GENERAL PRACTITIONERS. RATIONED HEALTH CARE.

173 ADOPT THE RECOMMENDATIONS OF THE PEPPER COMMISSION.

418 COOPERATIVE EFFORT BY STATE, FEDERAL GOVERNMENT AND EMPLOYERS TO MAKE UNIVERSAL INSURANCE AVAILABLE. RATIONING WILL BE NECESSARY.

161 COORDINATED, EFFICIENT, NATION-WIDE PLAN WITH RATIONAL TERMINAL CARE. THIS SYSTEM MUST BE EASILY ADAPTABLE TO NEW TECHNOLOGY, MUCH AS OUR CURRENT SYSTEM IS.

250 ESTABLISH A LEVEL AT WHICH PT CAN RECEIVE ASSISTANCE FOR MEDICAL COSTS WITHOUT REQUIRING THEM TO DISPOSE OF ALL ASSETS AND QUIT THEIR JOBS TO BE ELIGIBLE FOR HELP.

453 EXPANDED FEDERAL AND STATE SUPPORT FOR RURAL HEALTH CARE. MANDATED PHYSICIAN & HOSPITAL COVERAGE OF THE INDIGENT NEEDY. NATIONAL HEALTH CARE, PROVIDING A DOLLAR LEVEL OF HEALTH FOR EACH PERSON.

188 FEDERAL HLTH INSURANCE.

246 FEDERAL PROGRAM.

81 FEDERAL UNIVERSAL HEALTH CARE.

99 FEDERALLY OR STATE SUPPORTED MEDICAL PROGRAM.

48 GOVERNMENT SPONSORED HEALTH PLAN.

450 I RECOMMEND NATIONAL HEALTH SERVICE FOR EVERYONE REGARDLESS OF ABILITY TO PAY OR SOCIO-ECONOMIC STATUS. ELIMINATE INSURANCE INDUSTRY IN HEALTH MATTERS.

35 I WOULD RECOMMEND A NTL HLTH INS.PLAN THAT COVERS THE BASIC HLTH NEEDS OF ALL CITIZENS. THIS COULD BE SUPPLEMENTED BY PRIVATE INS.TO COVER MORE EXPENSIVE & ELECTIVE HLTH CARE. THE ST. OF MT DOESN'T HAVE THE TAX BASE TO DO THIS ON IT'S OWN.

438 IMPROVE THE NATIONAL SOCIAL CONSCIENCE.

180 IN BILLINGS THESE PEOPLE ARE ABLE TO GET CARE. NATIONWIDE, THEY WILL NOT GET CARE UNTIL THERE IS SOME KIND OF NATIONAL PLAN.

446 INSURANCE COVERAGE FOR EVERYBODY. DIVISION OF SICK PERSONS TO TEACHING INSTITUTIONS, AS IN THE PAST.

206 MAKE THE GOVT PAY FOR THEM - PROMPTLY EQUITABLY AND WITHOUT HASSLE TO PATIENT OR MD.

156 MANDATORY INSURANCE PROGRAM RUN BY COMBINATION PRIVATE/PUBLIC SECTOR.

325 MODIFICATION OF CANADIAN SYSTEM WITH EMPHASIS ON PREVENTION GOOD NUTRITION AND FULL ACCESS FOR ROUTINE MEDICAL CARE. LIMIT ACCESS FOR "HIGH TECH" I.E. TRANSPLANT & C.U. SURGERY (VEIN GRAFT).

314 NATIONAL HEALTH CARE PLAN.

464 NATIONAL HEALTH CARE.

470 NATIONAL HEALTH INSURANCE FOR ALL.

416 NATIONAL HEALTH INSURANCE.

69 NATIONAL HLTH CARE.

77 NATIONAL HLTH CARE FOR ALL CITIZENS. ELIMINATE TORT SYSTEM. STATE AND NATIONAL RATIONING PROGRAM >50% OF HLTH CARE $ IS FOR SELF INFLICTED BEHAVIORS. RATIONING PROGRAM NEEDS TO ESTABLISH INCENTIVES FOR A CHANGE IN BEHAVIOR.

302 NATIONAL HLTH CARE NOT RUN THROUGH THE PRIVATE SECTOR. THERE IS TOO MUCH PROFIT BEING REAPED FROM DISEASE.

70 NATIONAL HLTH INSURANCE.

71 NATIONAL HLTH INSURANCE PRIVATELY ADMINISTERED.

223 NATIONAL HLTH INSURANCE.

139 NATIONAL HLTH PLAN TO COVER THOSE WITHOUT ACCESS TO OR INSUFFICIENT INCOME TO BUY HLTH INSURANCE.

211 NATIONAL HLTH POLICY.

230 NATIONAL HLTH PROGRAM. LEGISLATION TO MAKE ALL PRACTITIONERS SEE/TAKE CARE OF MEDICAID PATIENTS (SIMILAR TO WHAT MASS.DID FOR MEDICARE).

184 NATIONAL REFORM.

148 NATIONAL SUBSIDY.

220 NATIONAL UNIFORM HEALTH PLAN.

503 NEED A NEW HEALTH DELIVERY SYSTEM. WOULD RECOMMEND CANADIAN PROGRAM.

281 OBTAIN BROAD CONSENSUS FOR A NATIONAL SYSTEM OF HLTH INSURANCE THAT IS UNIVERSAL, COMPREHENSIVE, AND FUNDED BY A SINGLE PAYOR.

105 OREGON PLAN-PRIORITIZE/"RATION".

42 PROBABLY NEED SOCIALIZED MEDICINE-NATIONWIDE PLAN FOR EVERYONE.

451 PROVIDE SOME MEANS OF EQUALLY DISTRIBUTING CHARITY CARE PATIENTS BETWEEN PROVIDERS IN EACH SPECIALTY. MOVE TOWARD NATIONALIZED SYSTEM OF HEALTH CARE PAYMENT.

106 RECOMMEND LOCALLY SUBSIDIZED BY GOVT.

16 SAME AS #12

57 SET UP SYSTEM AND PRIORITIZE HLTH CARE THAT EVERYONE SHOULD RECEIVE & PROVIDE THAT CARE ONLY. IF PEOPLE WANT FUTURE CARE THEY PAY FOR IT.

116 SOCIALIZE MEDICINE AND INSTITUTE MORE RATIONAL RATIONING THAN WE HAVE NOW.

32 SOCIALIZED MEDICARE CANADA.

84 SOCIALIZED MEDICINE.

296 SOCIALIZED MEDICINE.

436 SOCIALIZED MEDICINE.

352 SOME FORM OF NATIONALIZED HEALTH INSURANCE SEEMS TO BE THE ONLY REALISTIC OPTION. THIS SHOULD PREFERABLY BE ADMINISTERED BY THE PRIVATE SECTOR TO AVOID THE INEFFICIENCIES OF GOVERNMENT RUN PROGRAMS.

322 STATE OR FEDERALLY FUNDED CATASTROPHIC MEDICAL INSURANCE.

231 THIS WHOLE SUBJECT NEEDS THOROUGH STUDY BY NEUTRAL EXPERTS IF POSSIBLE. IT MAY BE TIME FOR FREE MEDICAL CARE FOR EVERYONE.

361 UNIVERSAL HEALTH CARE SYSTEM. PHYSICIANS SHOULD BE SALARIED. LAB/XRAY COSTS SHOULD BE CONTROLLED. NO PHYSICIAN SHOULD HAVE ANY FINANCIAL INTEREST IN LAB/XRAY TESTS HE OR HIS ORGANIZATION ORDERS.

400 UNIVERSAL INSURANCE.

82 UNIVERSAL TAX SUPPORTED FEDERAL/STATE PROGRAM, ELIMINATING PRIVATE INSURANCE SYSTEM.

276 USE PRIVATE INSURERS TO FORM A PLAN THAT IS SUPPORTED W/TAX REVENUES. INCLUDE ALL PEOPLE IN HLTH CARE PLAN. GOVT MAY SET STANDARDS AND TAKE BIDS FROM INSURERS, BUT NOT BECOME INVOLVED IN THE INSURANCE BUSINESS.

31 WE NEED SOME KIND OF NATIONAL HEALTH INSURANCE.

452 WE NEED UNIVERSAL MEDICAL INSURANCE - THE QUESTION IS WHO SHOULD PAY FOR IT? WE ALSO MUST CONTROL MEDICAL COSTS.

132 A MODERATE AMOUNT OF HLTH CARE SHOULD BE AVAILABLE TO ALL THROUGH FEDERAL OR STATE PROGRAMS. A DOLLAR A PACK TAX ON CIGARETTES WOULD RAISE LOTS OR MONEY.

23 NTL HLTH CARE PROGRAM WHICH WOULD COVER EVERYONE.BUT,ACCESS TO "WONDERKIND" TECH. MUST BE LIMITED ESOTERIC TESTS,"DIALYSIS FOR DRUGGIES"TRANSPLANTS ETC.PEOPLE LIVE!PEOPLE DIE!HLTH CARE @ ANY COST IS EXTREMELY COST INEFFECTIVE,ALLOW MERCY KILLING.

414 INCENTIVES FOR PHYSICIANS TO PRACTICE IN OUR RURAL, POORER REGIONS. CONSIDER CANADIAN-STYLE NATIONAL HEALTH INSURANCE PLAN.

386 INCENTIVES FOR PROVIDERS TO PROVIDE MORE CARE. MANDATED COVERAGE BY INSURANCE COMPANIES FROM TIME OF BIRTH. INCREASE THE NUMBER OF PEOPLE ELIGIBLE FOR MEDICAID. UNIVERSAL HEALTH INSURANCE FOR ALL PEOPLE TO BE ADMINISTERED BY THE FEDERAL GOVT.

131 INSURED, UNINSURED, MEDICAID CLASSIFICATION RESULT IN A DEFACTO CAST SYS.& PROVIDER BIAS TOWARD THESE PEOPLE. WHERE THE CANADIAN SYS.OF A "SINGLE PAYOR" IS OF ADVANTAGE. EVEN IF A PT HAS COVERAGE SUCH AS MEDICAID THE PRE-EXISTING BIASES NOT GUAR.HLTHCARE.

109 NATIONAL HLTH INS. & ABOLITION OF THE TORT SYSTEM IN CASES OF MEDICAL INJURY.

PATIENT RESPONSIBILITY

268 EST.SYS.WHERE ALL PTS W/LOW INCOME HAVE ACCESS TO CARE, BUT FORCES THEM TO ACCEPT RESPONSIBILITY FOR ACTIONS. FREQUENT UNNECESSARY CALLS AFTER HRS OR ER VISITS ARE IRRESPONSIBLE AND COSTLY. REWARD THOSE PTS WITH RESPONSIBLE ACTIONS.

66 EDUCATION-MANDATORY CLASS INSTRUCTION FOR THOSE TRYING TO GET ASSISTANCE. PEOPLE CAN ONLY PAY A LITTLE-THAT'OK, BUT DON'T OWE THEM A FREE RIDE.A PROGRAM THAT WOULD HELP THESE GET APPOINTMENTS & INTERESTED PHYS.-TAX INCENTIVES TO PHYS. SEE SURVEY #66.

127 MAKE HLTH CARE UNIVERSALLY AVAILABLE TO ALL CHILDREN & PREGNANT WOMEN. MEDICAID-INS.TO COVER ALL THE ABOVE. CUT COSTS BY MORE AGGRESSIVE MANAGEMENT OF MEDICAID USERS WHO ABUSE THE SYSTEM. GET THEM OUT OF THE ER'S.

74 STATE PROGRAM TO TRADE COMMUNITY SERVICE FOR HEALTH CREDITS.

471 PROVIDE MALPRACTICE RELIEF FOR EMERGENCY ROOMS AS THEY ATTEMPT TO SCREEN NON EMERGENT CASES TO REDUCE COSTS. EXTEND COVERAGE OF INDIGENTS WITH SOME PATIENT RESPON & SPECIAL TAX LEVY IF PUBLIC EXPECTS HEALTH CARE FOR ALL AS A RIGHT. THEY PAY FOR IT.

493 METHODS SHOULD BE DEVISED TO PROVIDE CARE MORE ON THE BASIS OF NEED THAN AGE. IN OTHER WORDS, THOSE WHO ARE UNABLE TO PAY SHOULD HAVE ACCESS TO MEDICAL CARE REGARDLESS OF AGE.

283 I THINK IT WOULD BE HELPFUL TO HAVE HLTH CARE PROVIDED FOR THOSE WORKING LOW INCOME JOBS RATHER THAN ENCOURAGING PEOPLE TO GO ON WELFARE, ADC, BY STOPPING ALL EFFORTS OF EMPLOYMENT.

472 I THINK TITLE 19 ASSISTANCE (FOR MEDICAL CARE ONLY) TO PEOPLE IN LOW INCOME JOBS, WHOSE INCOME IS TOO LOW TO AFFORD MEDICAL CARE.

107 DECREASE BENEFITS TO THOSE WHO DO NOT NEED IT OR ABUSE IT. OUR STATE IS LOSING $ BECAUSE IT IS BACKWARDS. MEDICAID PTS ARE 10 TIMES AS LIKELY TO GO TO THE DR FOR NON-ILLNESS THAN OTHER PEOPLE BECAUSE IT IS FREE.

312 "MEANS TESTING" TO ALLOW IDENTIFICATION OF THOSE WHO CANNOT AFFORD TO PAY, WHILE EXPECTING THOSE WHO CAN AFFORD IT TO PAY FOR THEIR CARE.

203 1)ALL PTS SHOULD PAY A MIN.CHARGE,SO IT'S NOT "FREE"MEDICINE. 2)MUST RETHINK MAJOR FACTOR THAT MAKES MEDICINE SO EXPENSIVE(2 CT IN BZN).3)MUCH MORE COSTS WHEN LET THE GOVT DO IT(GET IT OUT OF THEIR DOMAIN). 4)GET COSTS DOWN 50% IN THE NEXT YEAR.

502 A SYSTEM THAT ALLOWS ANYONE TO PAY FOR NONE OF THEIR HLTH CARE INVITES MISUSE. SHOULD BE RESPONSIBLE FOR % OF THEIR CARE, HOWEVER SMALL. THE PTS I HAVE ON MEDICAID ARE THE BIGGEST ABUSERS. THEY COME IN FOR VERY MINOR PROBLEMS.

112 EMPHASIZE SELF RESPONSIBILITY AND PENALIZE FOR ABUSING SYSTEM.

205 FEDERAL FUNDING TO PURCHASE BASIC INSURANCE COVERAGE FOR EVERY ON A SLIDING INCOME SCALE. (TAKE THE MONEY FORM THE MILITARY BUDGET).

398 FREE CARE IS OVER UTILIZED. THERE WOULD BE MORE THAN ENOUGH CARE & USAGE IF LIMITED TO THOSE WHO REALLY QUALIFY.

185 GET MORE JOBS SO THEY CAN PAY FOR THEIR CARE. GET THEM OFF WELFARE ROLLS & INFO EMPLOYMENT WITH THE PRIVATE SECTOR.

407 LOW PAYING EMPLOYEES CANNOT AFFORD QUALITY HEALTH INSURANCE. THEY MIGHT BE ABLE TO PAY FOR LESS EXPENSIVE INSURANCE WITH A HIGH DEDUCTIBLE AND THEN GET ASSISTANCE IN MEETING THIS DEDUCTIBLE. WHEN ITS FREE IT'S SO EASILY ABUSED BY ALL INVOLVED.

404 MAKE AFFLUENT MEDICARE PATIENTS GET OFF MEDICARE. GIVE THE POOR WHO CAN'T AFFORD MEDICAL CARE THE BENEFITS THAT ARE BEING GIVEN TO THE RICH. ELDERLY OVER 65 ARE THE WEALTHIEST IN THE US. MORE DISPOSABLE INCOME. STOP SUBSIDIZING FOR THOSE PEOPLE.

125 MUST HAVE "GATE" KEEPER TO CUT DOWN ON ABUSE AND OVER UTILIZATION-WANT TO AVOID ALL THE PIT FALLS OF MEDICAID PROGRAM.

365 NEED A PROGRAM BASED ON ABILITY TO PAY. TO SIMPLY SAY A CERTAIN GROUP OF PEOPLE CAN'T PAY IS ONLY POTENTIATING THE FINANCIAL PROBLEM WITH MEDICAL CARE BY COST SHIFT, SHUNTING OF CARE TO INSTITUTIONS, AND OVER UTILIZATION.

47 NONE-GET A JOB.

126 NOT CHARGING THOSE WHO CAN'T PAY. THOSE ON WHOM IT IS A TERRIBLE BURDEN. IF WE DON'T, SOON THE GOVT WILL DO IT FOR US.

175 OFFER OF WORK, COMMUNITY ET AL, WITH HLTH PLAN INCLUDED (INSURANCE OR OTHER PRE-PAID).

340 PAY FOR HEALTH CARE PROVIDING THE DON'T SMOKE, HAVE TUBAL LIGATION OR VASECTOMY. FUNDS AVAILABLE VIA FEDERAL PROGRAM. MUST MEET ABOVE CRITERIA BEFORE QUALIFYING (IF 2 OR MORE CHILDREN).

489 PUBLIC ASSISTANCE AND MEDICAID GIVEN FOR FREE DOES NOTHING FOR THE PEOPLE RECEIVING IT BECAUSE THEY DON'T LEARN TO APPRECIATE IT BUT EXPECT IT. IF THEY WERE ASKED TO PROVIDE SOME SORT OF PUBLIC WORK IN EXCHANGE FOR THOSE SERVICES IT WOULD BE BETTER.

130 RE-INSTATEMENT OF BARTER SYSTEM OR SMALL PMTS OVER EXT.TIMES TO PAY PHYS.& LESS DEPENDENCE ON INS.COS.PRIVATE OF FED.GUARANTEED. TOO MANY PEOPLE HAVE COME TO CONSIDER INS.AS BEING TOTAL HLTH CARE COVERAGE WHEN INS.COS.COVER ONLY CERTAIN COSTS. SUR #130.

346 REDUCE COSTS OF PROVIDING HEALTH CARE BY CUTTING DOWN UNNECESSARY USE OF RESOURCES BY MEDICAID PATIENTS. SOME SYSTEM OF SCREENING AND MONITORING OF THIS MISUSE COULD SAVE A LOT OF MONEY.

371 REQUIRE EVERY EMPLOYED PERSON TO A MINIMUM LEVEL OF HEALTH INSURANCE. IT IS THE WORKING POOR WHO HESITATE THE MOST TO ENTER THE HEALTH CARE SYSTEM.

465 RESPONSIBILITY RESTS ON THE FAMILY MEMBERS. INS COMP SHOULD TAKE A HARD LOOK AT THEIR CONT LOSS OF CLIENTAL DUE TO SHARP RISES IN COSTS TO FAMILIES. SOC SECURITY SHOULD BE LIMITED TO MEMBERS THAT HAVE CONTRIBUTED.

334 SLIDING SCALE PAYMENTS WITH QUALIFIED HEALTH INSURANCE PLANS.

15 SOME TYPE OF INSURANCE OR GOVT HELP FOR ANYONE WHO WANTS IT-PREMIUM SLIDING SCALE-BASED ON ABILITY TO PAY (IE NET INCOME) ASSETS ETC.

215 TAX TO THE MAX ITEMS RELATED TO AN UNHEALTHY LIFESTYLE(ALCOHOL,CIGARETTES) & USE INCOME FOR MEDICAL COSTS. PROVIDE MEDICARE ONLY TO THOSE FINANCIALLY IN NEED OF IT; MANY SENIORS CAN AFFORD PRIVATE INSURANCE.

376 THE IDEA THAT A MILLIONAIRE OVER 65 GETS FREE MEDICAL CARE & THAT A YOUNG FAMILY WITH A CHRONICALLY ILL CHILD GETS NOTHING MAKES NO SENSE. EVERYONE SHOULD BE REQUIRED TO PAY SOMETHING. ALL MEDICAL FIELDS SHOULD CUT THEIR FEES & CHARGES BY 10%.

38 THERE ARE TOO MANY PEOPLE FREE LOADING OFF THE SYSTEM WHO ARE CAPABLE OF PAYING. MANY OF MY MEDICAID PATIENTS COME IN DRESSED WITH EXPENSIVE CLOTHES.

435 TIGHTER CONTROL OF WHO IS GIVEN FREE HEALTH CARE, SO THERE WILL BE MORE MONEY FOR THOSE WHO REALLY CANNOT AFFORD IT.

477 UTILIZE TAX REVENUES GENERATED FROM TAXES ON RICES WHICH EITHER CAUSE OR SIGNIFICANTLY CONTRIBUTE TO CHRONIC MEDICAL PROBLEMS TO FINANCE HEALTH CARE FOR THOSE WITH INSUFFICIENT OR NO HEALTH CARE COVERAGE. MAYBE A SPECIAL STATE LOTTERY TO HELP COSTS.

476 MAKE HEALTH CARE AVAILABLE BASED ON NEED NOT AGE. THE WEALTHY HAVE TO PAY THEIR SHARE REGARDLESS OF OTHER FACTORS.

<u>RATIONING</u>

469 COMPLETE OVERHAUL OF THE SYSTEM. ELIMINATION OF EXPENSIVE & USELESS THERAPIES AT THE END OF LIFE & EXPANSION OF BENEFITS FOR CHILDREN. THIS WOULD HAVE TO INCLUDE PREVENTATIVE HEALTH MEASURES. OREGON SYSTEM GOOD MODEL & SHOULD BE APPLIED UNIVERSALLY.

55 "RATION" HLTH CARE; INCREASE THOSE ELIGIBLE FOR ASSISTANCE.

293 1)PEOPLE NEED TO BE UP FRONT ABOUT INABILITY TO PAY(ADJUSTMENTS CAN BE MADE)-PROVIDE SAMPLES, MIN.LESS CRIT.TESTING 2)RATIONING OF MORE EXPENSIVE PROCEDURES TO ALLOW FOR BASIC HLTH CARE PROVISIONS-HEAVEN HELP THOSE WHO WILL HAVE TO DECIDE.

87 1)SET PRIORITIES-QUESTION 5 2)FUND PRENATAL CARE 3)LOWER COST OF LIABILITY INS., THUS LOWERING HLTH CARE PROVIDER OVERHEAD 4)FUND CARE AS PRIORITIES AND FUNDS ALLOW 5)STATEWIDE INS.POOL AVAIL.TO SELF EMPLOYED &SMALL BUS.,AGRICULTURE AND TIMBER.

485 CUT THE PAYMENTS TO HIGH PAID PROCEDURE SPECIALISTS & THE MONEY LEFT OVER COULD PAY FOR PEOPLE AT 200% OF POVERTY LEVEL.

282 DECISIONS BASED ON RECOMMENDATIONS BY A COLLABORATION INCLUDING: MEDICAL ASSOC.MEMBERS, COUNTY WELFARE BOARD, COUNTY HLTH DEPT.,COUNTY COMMISSIONERS, CITY GOVT.

274 I WOULD BE AVAILABLE TO HELP ANY TRULY NEEDY INDIVIDUAL NEEDS CARE, BUT SOME ABUSE IT WHILE I AM DISCOUNTING THEIR CARE. THE PROBLEM IS IN DOCUMENTATION OF NEED. THOSE WHO RECEIVE TEND TO ABUSE ACCESS UNNECESSARILY FURTHER DELAYING TREATMENT TO OTHERS.

374 I WOULD RECOMMEND THE AMERICAN ACADEMY OF PEDIATRICS PLAN FOR HEALTH CARE FOR PREGNANT WOMEN AND CHILDREN AS A START.

234 MONTANA MUST DECIDE WHAT IS MEDICALLY NECESSARY AND SUPPLY THIS CARE TO THE UNINSURED IE MEDICAID ELIGIBLE AND THE WORKING POOR WHO HAVE NO INSURANCE.

459 NO EASY ANSWERS - IF THERE WAS SOME METHOD OF SCREENING PATIENTS TO IDENTIFY THOSE IN TRUE NEED, I'D SEE THEM WITHOUT CHARGE.

141 PRIORITIZE IE. SOME FORM OF RATIONING.

64 SOME FORM OF INS. FOR MINIMUM STANDARDS. OUR STANDARDS OF MEDICAID/MEDICARE CARE ARE FREQUENTLY TOO IDEALISTIC-EG SOCIAL SERVICES, PHYSICAL THERAPY, & MAXIMUM HEROIC MEASURES FOR THE VERY ELDERLY AND TERMINALLY ILL PATIENTS.

397 THE COST OF RUNNING MEDICARE PROGRAM IS A HEAVY BURDEN ON THE YOUNG. THE RATIONING WILL BE DETRIMENTAL TO THE HEALTH OF THE ELDERLY. LET US TAKE CARE OF THOSE IN NEED & PERMIT THE REST TO PURCHASE THEIR CARE. LEAVE MONEY IN PEOPLE'S POCKETS.

332 TO DECREASE EXPENDITURES IN HOSPITAL PATIENTS. RESTRICT TRANSPLANTATION TO A VERY FEW AND SELECTED. TO RESTRICT CARE IN ONE WORD. TO DECREASE PAYMENT TO HIGH PRICE SPECIALISTS. TO GIVE CARE TO ALL.

272 WE RATION MEDICAID/CARE NOW BY INADEQUATE PMTS TO COVER COSTS. TO EXPAND CARE MORE MONEY IS NEEDED. IF WE MUST RATION AND WE MUST-THIS IS A SOCIO-ECONOMIC PROBLEM NOT A MEDICAL ONE.

369 WEALTHY ELDERLY TO PAY THEIR FAIL SHARE. RATION CARE AT END OF LIFE. ELECT LEGISLATORS/CONGRESS WITH COURAGE TO IMPLEMENT ABOVE. HOSPITALS & PHYSICIANS SHOULD COME CLEAN IN PUBLIC ABOUT ACTUAL COST OF MEDICAL CARE & WHETHER IT ACTUALLY WORKS.

29 1)INCENTIVES FOR THOSE PHYS.WILLING TO SEE THESE PATIENTS SO THEIR PRACTICE DOESN'T BECOME INUNDATED WHILE OTHER PRACTITIONERS REFUSE TO SEE THESE PATIENTS. 2)INFORMATION SYSTEMS SO PEOPLE CAN FIND THESE PHYSICIANS.

263 1)LOOK GOT LOWER COST ALT.SUCH AS USE OF LICEN.NURSE, MIDWIFE, PA UNDER MD SUPERVISION 2)TORT REFORMS SO THAT CAN PRACTICE GOOD MEDICINE IN COST EFFECTIVE FASHION(RATHER THAN DEFENSIVELY IN LIEU OF MALPRACTICE SUIT).

193 1)MAKE WRITING OFF OF DEBTS A DEDUCTIBLE EXPENSE OF DOING BUSINESS. 2)SLASH DEFENSE SPENDING BY AT LEAST 50%.

501 ALLOW DOCTORS TO DEDUCT TREATMENT OF THESE PEOPLE FROM THEIR INCOME TAXES.

338 COMMUNITY/HOSPITAL/PRIVATE WORK PROGRAMS FOR THOSE ON PUBLIC ASSISTANCE. STRICT GUIDELINES FOR DOCTOR OFFICE AND E.R. VISITS TO PREVENT OVER UTILIZATION. TAX DEDUCTIONS FOR PHYSICIANS UNCOLLECTIBLE DEBTS.

176 DECREASE GOVT REGULATION TO ALLOW FOR MORE PHYSICIAN DIRECTED CHARITY.

95 EMPLOYER TAX CREDITS FOR INSURANCE TO COVER EMPLOYEES. EXPANDED GOV'T ROLE FOR UNEMPLOYED FOR MINIMUM BASIC SERVICES.

265 IF SYSTEM DOESN'T ALLOW FOR MEAN TO PAY IT SHOULD ALLOW A MEANS OF DEDUCTING OR "WRITING OFF" THE BAD DEBT.

186 PAY MD ENOUGH TO CARE FOR MEDICAID PTS. TAX CREDITS FOR EMPLOYERS TO PROVIDE HLTH INSURANCE.

86 PRESENT PROGRAMS SEEM TO HAVE EXCESSIVE BUREAUCRATIC PAPER WORK-THIS NEEDS TO BE REDUCED, ALSO THE HLTH CARE PROVIDER SHOULD BE ALLOWED TO CLAIM A "CHARITABLE DEDUCTION" ON TAXES IF HE CHOOSES TO GIVE THE CARE FREE INSTEAD OF FIGHTING THE RED TAPE.

135 PROVIDE COMPENSATION FOR PRIVATE CARE PHYSICIANS TO PAY FOR THOSE UNABLE TO PAY FOR THEIR MEDICAL CARE.

160 REQUIRE THAT EMPLOYEES PROVIDE HLTH CARE BENEFITS EVEN TO PART TIME EMP.ON A % BASIS, BASED ON % OF EMPLOYMENT. MANY PEOPLE ARE W/OUT HLTH CARE BENEFITS BECAUSE THEY ARE NOT PERMITTED BY EMPLOYER TO WORK FULL TIME SO THEY CAN BENEFIT FROM HLTH CARE.

320 SALES TAX OR SOME FORM OF CONSUMPTION TAX TO PAY FOR CARE FOR SUCH PEOPLE.

321 TAX ALCOHOL AND TOBACCO AND 90% OF THE TAX INCOME SHOULD GO TO HEALTH CARE IN THE STATE OF MT. THE OTHER 10% SHOULD GO TO EDUCATION TO PREVENT SMOKING AND ALCOHOL ABUSE.

496 TAX BREAK INCENTIVES FOR PHYSICIANS WHO CARE FOR THESE CASES. TAX INCENTIVES, (DEDUCTIONS FOR EXPENSE NOT COVERED) TO CARE FOR MEDICAID PATIENTS.

174 TAX CREDITS AND INCENTIVES TO PURCHASE ADEQUATE HLTH INSURANCE. MANDATORY PAYROLL DEDUCTION WITH TAX CREDITS.

5 TAX INCENTIVES FOR PROVIDERS OF UNCOMPENSATED CARE.

54 TAX INCENTIVES TO ALL BUSINESS TO PROVIDE MANDATORY HLTH INS. (IE TAX BREAKS TO THE EMPLOYERS). NURSE PRACTITIONERS IN OUTLYING AREAS.

364 TAX INCENTIVES TO INDIVIDUALS AND HOSPITALS FOR RENDERING SUCH CARE.

278 TAX INCENTIVES TO PHYS.WHO PROVIDE CARE FREE OR AT REDUCED FEES.

382 USE TAX INCENTIVES TO HAVE BUSINESS OFFER HEALTH COVERAGE TO THEIR EMPLOYEES.

OTHER COMMENTS

300 FEDERAL/STATE GOVT. INCREASE SPENDING ON VULNERABLE POPULATIONS. CONTROL INSURANCE COMPANY PRACTICES. MISSOULA CO. HAS BEGUN A GOOD PROGRAM OF SPREADING THE BURDEN OF UNCOMPENSATED CARE.

46 A COMPLETE PROBLEM. PREFER TO AMA'S "HEALTH ACCESS AMERICA" AND GOV.STEPHENS PLAN.

429 ABOUT 1/2 OF MY PROFESSIONAL LIFE HAS BEEN IN PRIVATE PRACTICE & 1/2 IN SALARIED JOBS. THE PERCENTAGE OF GOOD & INFERIOR IS THE SAME IN BOTH PLACES. I DOUBT THAT ANYTHING THAT I HAD AS A SALARIED PHYSICIAN WOULD BRING THE COST OF MEDICAL COST DOWN.

59 ACCESS TO HLTH CARE IN THIS AREA IS VERY ADEQUATE.

248 AMA ACCESS AMERICA PROGRAM.

297 BELIEVE THE ONLY SOLUTIONS LIE IN CREATIVE COMMUNITY EFFORTS INVOLVING VOLUNTEERS, CHURCH & COMMUNITY SERVICE GROUPS, & RELYING ON GOVT SERVICE ONLY FOR SPECIFIC SERVICES LIKE IMMUNIZATION, STD'S, AND FAMILY PLANNING.

255 COUNTY ASSISTANCE.

351 DECREASE DEMAND.

494 ESPECIALLY HELP YOUNG WORKING COUPLES, ESPECIALLY WITH CHILDREN.

309 HAVE A SIMILAR PROGRAM FOR THEM, AS MONT SHARE IS FOR THE ELDERLY.

41 HAVE SOCIAL WORKERS WORK WEEKENDS ONLY.

292 I DO NOT SEE A PROBLEM LOCALLY NO ONE IS REFUSED CARE TO MY KNOWLEDGE.

150 I'M PRETTY MUCH IN FAVOR OF GOV.STAN STEPHEN'S PROPOSAL AS I UNDERSTAND IT.

83 INCREASE FUNDING FOR THOSE PATIENTS UNABLE TO PAY.

119 LAST REPORT FROM DEERING HEALTH CENTER INDICATED THAT DR.SCHECKELTON HAD BEEN UNABLE TO DOCUMENT ANY ACCESS PROBLEM.

36 MAJOR SOCIAL PROBLEM WHICH SOCIETY HAS YET TO SOLVE OR EVEN COME TO GRIPS WITH.THESE PEOPLE "TAX" THE INSURED SIGNIFICANTLY AS I SEE IT THERE ARE FEW OPTIONS 1)NO CARE 2)SAME 3)EMPLOYER PAYS 4)TAX PAID COVERAGE 5)FREE CARE BY DRS AND HOSPITALS.

275 NONE, I BELIEVE MOST DRS SEE THE PTS.

456 PLEASE REFER TO AMERICAN COLLEGE OF PHYSICIAN PLAN WHICH WILL BE PUBLISHED IN 1991. I AM WORKING ON IT AS A MEMBER OF THE BOARD OF REGENTS OF THE A.C.P.

390 PROVIDE FOR TRAVEL EXPENSES.

Q12. If you were to design a program which would improve the health care of the underinsured, what would you do?

LESS BUREAUCRACY OR CHANGES IN MEDICAID/MEDICARE

RESPONDENT #

428 AGAINST SOCIALISM & ALL ITS PROG. WHEN I GIVE A DOLLAR TO MY PTS, HE GETS A DOLLAR. THE STATE GIVES $1, TAKES $3 TO GIVE 1 & KEEPS $2. FED GOVT GIVES $1, TAKES $5 FROM US TO GIVE PTS $1. A GOVT WHICH PROVIDES ALL NEEDS HAS SLAVES FOR CONSTITUENTS.

107 AS I SAID BEFORE. UTILIZE THE FUNDS THAT ARE AVAILABLE MORE EFFICIENTLY.

408 CUT DOWN TANGLE FOR PAYMENT OF PHYSICIAN FOR MEDICAID AND MEDICARE. IF DOESN'T PAY PHYSICIAN TO CATER TO THE GROUP AS IT NOW STANDS.

458 DECREASE MY OFFICE OVERHEAD EXPENSES BY GETTING THE GOVT OUT OF MEDICINE. THIS WOULD ALLOW ME TO GREATLY DECREASE THE COST TO ALL PATIENTS.

10 ELIMINATE PORK BARREL PROJECTS AND OTHER WASTE IN STATE AND FEDERAL GOVERNMENT AND PROVIDE UNIFORM HEALTH CARE PROGRAM WITH MONEY SAVED.

397 EVERYONE KNOWS THE MEDICARE FAILURE TO PAY OF WELL COST FOR MEDICAID-ESPECIALLY HOSPITAL CARE-CAUSES TRANSFER OF THESE UNPAID CHARGES TO THE PRIVATE SECTOR CAUSING HUGE PRIVATE INS. PREMIUMS FOR THOSE NOT UNDER MEDICARE. GET RID OF MEDICARE.

78 EXPAND MEDICAID ELIGIBILITY AND SERVICES. THIS, HOWEVER, WOULD ONLY BE BAND-AID THERAPY I REALIZE.

286 EXPAND MEDICAID TO COVER THE UNDEREMPLOYED, UNEMPLOYED

89 EXPAND MEDICAL COVERAGE AND IMPROVE REIMBURSEMENTS TO MAKE IT ECONOMICALLY FEASIBLE TO TREAT THESE PATIENTS.

423 I DON'T FAVOR PROG THAT WILL ATTRACT ADDITIONAL WELFARE PATIENTS TO OUR STATE. I ALSO RESENT ANY ADDITIONAL GOVT INFLUENCE MANDATORY MORE FREE CARE THAN THE FEDERAL PROG HAVE ALREADY FORCED. MANY COLL. REFUSE MEDICAID PTS. ITS UNFORTUNATE.

274 I WOULD NOT LET THE GOVT ON ANY LEVEL MANAGE,CONTROL, OR USE THE SYSTEM. I WOULD BASE THE PROGRAMS IN CHARITY, RELIGIOUS GROUPS AND APPEAL TO HLTH PROVIDERS FROM THAT PERSPECTIVE. IE ADOPTION SERVICES.

351 KEEP GOVERNMENT OUT. LIMIT CARE TO USERS WITH PROVEN BENEFIT - OUTCOME ANALYSIS.

149 KEEP IT OUT OF THE HANDS OF THE GOVT.

393 KEEP PRESENT SYSTEM. NO MORE, EVEN LESS BUREAUCRACY. REALIZE ITS OKAY TO HAVE UNDERINSURED - ALL CAN'T HAVE ALL.

76 LIMIT ACCESS TO THOSE WHO CANNOT WORK AND WHO HAVE NO ACCESS TO OTHER HLTH CARE PROGRAMS (PHS,ETC.) SO THERE IS MORE MONEY AVAILABLE FOR THOSE WHO DEFINITELY REQUIRE ASSISTANCE.

101 MEDICAID COVERAGE FOR THOSE WITH LOW INCOME BUT UNABLE TO AFFORD PRIVATE INSURANCE. THESE PEOPLE ARE PENALIZED WHILE THOSE WHO DON'T, CAN'T, OR WON'T WORK ARE REWARDED.

305 MORE SUPPORT FOR FAMILY PLANNING SERVICES. STATE FUNDING FOR ABORTIONS FOR MEDICALLY INDIGENT

145 MY EXPERIENCE IN MT IS PRIMARILY MEDICAID PTS THROUGH OBSTETRICS. IF MEDICAID REMAINS SO LOW (REIMBUR.<OVERHEAD COSTS) THEN MORE PHYS.ARE GOING TO STOP PROVIDING THESE SERVICES. CONT.IN COMMENTS

287 REDUCE MEDICARE BENEFITS, ESTABLISH "NEED" SCREENS, ENCOURAGE PROVIDERS TO ACCEPT WHATEVER PTS CAN PAY.

465 REEVALUATE THE ENTIRE MEDICAID & AID TO DEPENDENT CHILDREN. WHEN POSSIBLE WORK SHOULD BE PAID. HAVE INS COMP OFFER A NO NONSENSE POLICY THAT'S AFFORDABLE. RESTRUCTURE MEDICARE TO ORIGINAL INTENT-INS FOR AGED 65 AND ABOVE.

262 REMOVE GOVT AT ALL LEVELS FROM HEALTH CARE

332 THE INSURANCE INDUSTRIES IS A SUCKER. I SUSPECT OF ANYTHING THAT IS MADE FOR PROFIT EVEN WITH BUREAUCRACY, EVEN WITH WASTE, SOCIALIZED MEDICARE IS BETTER BECAUSE IT IS FAIR.

294 THE MAJOR FACTOR THAT HAS CAUSED THE PROBLEM IS THAT THE FEDERAL PROGRAMS DO NOT COVER THEIR FAIR SHARE OF COSTS AND HAVE MADE HLTH CARE UNAFFORDABLE TO THE PRIVATE CITIZEN.

67 AVOID THE FEDERAL GOVERNMENT USE A CONTRIBUTING PLAN-EDUCATION FOR PATIENTS TO AVOID USING ER'S FOR ROUTINE CARE.

263 1)MORE BUREAUCRACY THE LESS MONEY GETS TO UNDERINSURED 2)NEED TO ENCOURAGE PRIVATE INDUSTRY AND PRIVATE INSURANCE TO CREATE COST EFFECTIVE MEANS.

425 ADEQUATE FUNDING OF MEDICAID PROGRAMS TO AT LEAST COVER THE MALPRACTICE COSTS OF PROVIDING OB CARE TO THE MEDICALLY INDIGENT.

386 I THINK THE ONLY SOLUTION IS A FEDERALLY ADMINISTERED UNIVERSAL HEALTH CARE PROGRAM. HOWEVER, IT MUST BE EFFICIENT & HAVE A MINIMUM OF RED TAPE AND BUREAUCRACY.

174 EXPAND MEDICAID COVERAGE FOR THE UNEMPLOYED AND UNEMPLOYABLE, MEDICARE FOR THE HANDICAPPED. COVER ALL WORKING PEOPLE WITH MANDATED BASIC COVERAGE (OPTIONAL ELABORATE COVERAGE) THROUGH THEIR EMPLOYMENT WITH TAX INCENTIVES.

164 1)PREVENT MEDICAID ABUSES 2)INCENTIVES TO PROVIDE CHARITY CARE 3)TOBACCO TAX TO INCREASE MEDICAID REVENUES

SPECIAL CLINICS

118 EXPAND PUBLIC HLTH SERVICE SYSTEM AND PROVIDE PRORATED CARE THROUGH THEIR CLINICS AND HOSPITALS FOR THE NEEDY.

75 HAVE COMMUNITY CLINICS

120 HIRE NURSE PRAC.TO MAN CLINICS AT BOTH SCHOOLS & LOCAL HLTH DEPT.(PROVIDE QUALITY PREVENTATIVE HLTH CARE SERVICES TO CHILDREN & REFER TO MD'S). PUB./PRIV. PROGRAMS SEEM TO WORK BETTER. NURSE PRAC.COULD SERVE @SATELLITE CLINICS TOO SMALL FOR PHYS.

290 I WOULD BE WILLING TO PARTICIPATE IN A LOCALLY RUN CLINIC FOR THE UNINSURED ON A PERIODIC BASIS.

176 INCREASE PERINATAL, PRENATAL AND INFANT CARE VIA FREE CLINICS STAFFED BY PHYSICIAN VIA TAX INCENTIVES.

259 ROUTINE HLTH CARE (MAINTENANCE, VACCINE COUNSELING) AT HLTH DEPT.OFFICES OR OTHER SITES-STAFFED BY COMMUNITY PHYS. AT A LOW BUT NON INSULTING REIMBURSEMENT.

136 SEE 9. NURSE PRAC.SCREEN CASES IN SMALLER COMMUNITIES & REFER TO LOCAL PHYS.WHEN CAN'T MANAGE. PAY MED.PERSONNEL ADEQUATE FEES. NEED SOURCE OF NEW INCOME FOR THIS. COULD BE CALLED A HLTH TAX & ADDED ON PURCHASES EXEMPTING FOOD & MED.CARE.

422 SET UP VOLUNTEER CLINICS SPONSORED BY MEDICAL SOCIETIES OR SOCIALLY CONSCIOUS GROUPS SUCH AS CHURCHES - PERHAPS SUPPORTED BY UNITED WAY THAT WOULD BE OPEN TO ALL IN NEED & COULD COORDINATE MORE COMPLEX CARE SUCH AS SPEC. REFERRALS OR HOSPITALIZATION.

330 STATE FUNDED CLINICS AND PHARMACIES - HIRE DOCTORS AND PAY THEM WELL. HAVE TO PREVENT PATIENTS FORM SEEING THE DOCTORS TO LIMIT ALL THIS STUPID DEFENSIVE MEDICINE. EASY APPROVAL TO GET INTO CLINIC BUT VERY STIFF PENALTIES FOR LYING/FALSIFYING ENTRY.

313 STATE OF COUNTY FUNDED PROGRAMS(CLINICS) WITH A REASONABLE RETURN FOR PHYS.WILLING TO WORK IN THEM WHICH WOULD INCLUDE THEIR MALPRACTICE COVERAGE.

EDUCATION/PREVENTION

86 1)EMPHASIZE PREVENTATIVE HLTH CARE 2)ENCOURAGE ROUTINE HLTH SURVEILLANCE PROGRAMS 3)EDUCATIONAL PROGRAMS ON HEALTHY LIFE STYLES-ENCOURAGE INSURANCE PLANS TO MOVE TOWARD THESE ABOVE 3 SUGGESTIONS.

128 BETTER EDUCATION WITH INCENTIVES FOR PROVIDERS TO HELP THESE PEOPLE.

437 DO IT THROUGH NON-MEDICAL MEANS. EDUCATION TO DEVELOP HEALTHY LIFE STYLES-DISEASE PREVENTION. INCENTIVES FOR HEALTHY LIFE STYLES. EXPAND FOOD SUPPLEMENT PROGRAMS-PERHAPS ATTACHED TO NUTRITION EDUCATION.

112 EDUCATE ON HIGH COST OF CARE AND TEACH THAT GOVT CAN'T AFFORD PREMIUM CARE FOR ALL.

21 EDUCATE THE PUBLIC, ELIMINATE CIGARETTES AND IMPRISON DRUNK DRIVERS. IS IT THE GOVERNMENTS RESPONSIBILITY TO PROVIDE HEALTH CARE?

442 IMPROVE EDUCATION PREVENTION & IMMUNIZATION PROGRAMS AS WELL AS FAMILY PLANNING & ACCENTUATE LOW BIRTH WT & PERINATAL HEALTH WITH OTHER STATE FUNDED PROG USED TO AMPLIFY NEED FOR COMPLIANCE & COMMITTED TO THESE HEALTH MAINTAINING & PREVENTIVE PROGS.

488 IMPROVE REIMBURSEMENT. SUBSIDIZE INS FOR THE WORKING POOR. IMPROVE PREVENTATIVE HEALTH CARE WITH INFORMATION AND EDUCATION. WE ALREADY DO THIS EG WITH SMOKING. WE COULD EXPAND THIS TO SEX, DIET, EXERCISE, ETC.

352 INCREASE EFFORTS TO EDUCATE THE POPULATION ABOUT LIFESTYLE EFFECTS ON ILLNESS. WE NEED TO ELIMINATE UNWANTED PREGNANCY, TOBACCO USE, ETOH. RELATED DISEASE, STD'S, ETC.

480 PREVENTIVE MEDICINE/PUBLIC HEALTH EDUCATION.

121 PUBLIC EDUCATION TO ENCOURAGE PEOPLE TO USE PRESENTLY AVAILABLE SERVICES AND TO PURSUE A HEALTHY LIFE STYLE-EXERCISE, DIET, AVOIDANCE OF SMOKING, ALCOHOL, ETC.

409 TEACH, TEACH, TEACH HEALTH PRINCIPLES IN ELEMENTARY GRADES. HIGH SCHOOL IS TOO LATE. TEACH THE PSYCHOLOGY, THE PHYSIOLOGY, OF SEX OF FAMILY, & THEIR RELATIONSHIPS TO SOCIETY AS WE WOULD LIKE IT TO BE & GOOD HEALTH. TEACH THAT ANY ACT HAS RESULTS.

431 WORK TOWARDS A GOVERNMENT SCHEME LIKE CONDO'S AFTER REEDUCATION OF THE PUBLIC. THE PUBLIC WANTS LOTS TECHNOLOGY & TODAY WHERE IN CONDO A STATE LIKE MT WOULD NOT HAVE A MRI UNIT LET ALONE THE CAT SCANNERS WE HAVE IN SMALL COMMUNITIES.

60 WOULD SPEND MORE IN PROVIDER REIMBURSEMENT FOR PREVENTIVE HLTH CARE.FIGHT TENDENCY TOWARD 2 TIERED MEDICINE BY OFFERING PROGRAMS THRU MEDICAL OFFICES.INSTITUTE "FREE"MONEY MGMT SERVICES BY QUALIFIED INDIVIDUALS. MANY UNDERINSURED DON'T SPEND $ RIGHT.

139 REQUIRE EMPLOYEES TO PROVIDE HLTH INS.-UNEMPLOYMENT & PART-TIME & ALL WITHOUT EMPLOYER INS.BE COVERED BY A FED.PLAN SIMILAR TO MEDICARE. DESIGN EDUCATION PROGRAMS ON HLTH RISKS OF OBESITY AND SMOKING.

66 EDUCATION TO CARE FOR THEMSELVES. WIPE OUT WELFARE SYS.FOR ABLE BODIED WORKERS.MOTHERS EDUCATED ON CARING FOR THEMSELVES AND FAMILY.DIFFICULT TO GET ASSIST.TO GET ALCOHOL AND TOBACCO.

15 EMPHASIS ON PREVENTION & HLTH EDUCATION THROUGH GOOD ROLE MODELS, GOVT, BUSINESS, SCHOOLS, ADVERTISING. INSURANCE PREMIUMS BASED ON SLIDING SCALE ABILITY TO PAY & REWARDS FOR NONABUSE, MISUSE OF HLTH CARE FACILITIES/SERVICES.

455 MAKE RECEIVING MEDICAID/MEDICARE DEPENDENT ON NO TOBACCO USE. MANDATORY PARTICIPATION IN PARENTING/NUTRITION CLASSES. IN CITIES THAT HAVE DIAPER SERVICE $4/CHILD/WEEK COULD BE SAVED. THIS MIGHT HELP FUND AT LEAST PART OF THE PROGRAM.

49 PREVENTION,EDUCATION,AND HLTH MAINTENANCE. WORK FOR THOSE WHO CAN WORK WITH MEDICAL COVERAGE.AMERICANS NEED TO BE MOTIVATED TO CARE FOR THEMSELVES. THERE IS TOO MUCH COMPLACENCY IN OUR SOCIETY. WE NEED TO RE-ESTABLISH THE WORK ETHIC IN THIS COUNTRY

411 STRICT SEVERE DRUNK DRIVING LAWS. INCREASE COSTS OF CIGARETTES TO PROHIBIT USE. OUTLAW CHEWING TOBACCO. ALLOW TESTING OF ALL PATIENTS ADMITTED TO HEALTH CARE FACILITY TO HAVE AIDS TESTS (HIV).

375 STRONG EMPHASIS ON PREVENTIVE MEDICINE. TOBACCO & ALCOHOL LEAD TO TREMENDOUS HEALTH COMPLICATIONS & SHOULD BE HEAVILY TAXED, ALL THE INCOME SHOULD BE USED AS FUNDING. EDUCATE PEOPLE. SOLICIT INPUT FROM MEDIA.

207 DISCOURAGE BIRTH RATES IN POOR POP. 1)FREE BIRTH CONTROL AND ABORTION 2)DECREASE WELFARE BENEFITS FOR EACH CHILD 3)REMOVE CHILDREN FROM HOMES WHERE POVERTY, IGNORANCE, VIOLENCE DESTROY THEM. NATIONAL HLTH CARE W/PT RESPONSIBILITY A MAJOR FACTOR.

195 INCREASE ACCESS, SHARE THE BURDEN, STRESS PREVENTION, RATION

GATEKEEPERS

54 1)GET THEM ALL TO GO TO A G.P. WHO COULD ACT AS RESPONSIBLE GATEKEEPER TO SPECIALISTS AND THEIR HIGH COST CARE. 2)TORT REFORM.

357 INCLUDE MORE DOCTORS IN DECISION MAKING PROCESS.

466 LOCAL GOVT WOULD DETERMINE WHO NEEDS HELP & IS TRULY NEEDY & DOCTORS WOULD WORK WITH LOCAL OFFICIALS & PATIENTS. INCENTIVES MAY HELP BUT I FEEL MOST DR'S WOULD SETTLE FOR LESS FINANCIAL REWARDS WITH LESS GOVT. HASSLE. MORE PROTECTION FROM LAWSUITS.

378 PROVIDE A SYSTEM WITH ACCESS & CONTINUITY OF CARE SUPERVISED BY PRIMARY CARE FOR WHOSE PATIENTS REFERRALS TO ER & SPECIALISTS MUST BE OKAYED AVOIDING DUPLICATION & UNNECESSARY HIGHER FEES. CREATE REASONABLE REIMBURSEMENT SYSTEM TO ALLOW SMALL PROFIT.

476 RESTRICT ACCESS TO ER/SPECIALISTS BY HAVING EVERYONE HAVE A PRIMARY CARE GATE KEEPER, WHO WOULD NOT BE AT FINANCIAL RISK FOR REFERRING OR NOT REFERRING TO THE SPECIALIST OR ER THE PT WOULD HAVE BENEFITS OF CONTINUITY OF CARE & LESS EXPENSE.

87 SEE #9 TRAIN FAMILY PHYSICIANS IN-STATE

62 THE DRS IN A COMMUNITY USUALLY KNOW WHO CAN AND CANNOT AFFORD CARE ALSO SOCIAL SERVICE MAY BE A HELP. IF WE HAD THE OLD SYSTEM THE PRICE WOULD BE LESS FOR DRS SERVICES, MORE FREE CARE CLINICS COULD BE SET UP IN A COMMUNITY.

MODIFY INSURANCE SYSTEM

57 COVER BASIC SERVICES ONLY FOR EVERYONE IN STATE.

23 CRACK DOWN ON INS.COS. MAKE THEM ACCOUNTABLE FOR THERE BILLS. GIVE PUNITIVE DAMAGES. INSURE ALL CITIZENS W/FEDERAL PROGRAM WHICH EVERYONE PAYS INTO. BAR ANY FED EMPLOYEE FROM TAKING JOBS W/INSURANCE CONNECTED INDUSTRY AFTER THEY LEAVE PROGRAM.

36 DECIDE WHO IS TO PAY THE BILLS, THEN FOLLOW THAT WITH A DECISION AS TO COVERAGE OF GROUPS. I WOULD ELIMINATE THE TAX DISADVANTAGE TO SELF PAID POLICIES-CURRENTLY NOT DEDUCTIBLE VERSUS EMPLOYER PAID DEDUCTIBLE. THIS IS SIMPLE AND MAY HELP A BIT.

239 DIFFICULT TO SUGGEST A SOLUTION. INCREASING GOVT INPUT WILL INCREASE COSTS & DECREASE QUALITY. LOOK AT VA SYSTEM FOR AN EXAMPLE. NEED TO DO SOMETHING THROUGH PRIVATE SECTOR. BUYING LEGITIMATE PRIVATE INS.FOR POOR.(EST.TO COST LESS THAN GOVT INS.)

421 DON'T REQUIRE THEY BECOME DESTITUTE PRIOR TO BECOMING ELIGIBLE. REQUIRE PHYSICIANS TO ACCEPT PATIENTS INSURED BY THESE PROGRAMS. PATIENTS SHOULD BE REQUIRED TO MAKE A CO-PAYMENT TO AVOID ABUSE. REIMBURSEMENT REASONABLE. ALL SHOULD BE ELIGIBLE.

255 EMPHASIS ON INS.IS MISDIRECTED. PEOPLE NEED HELP W/SERVICES NOT APPROPRIATELY COVERED BY INS.(OFFICE CALLS). WHEN SERIOUS ILLNESS STRIKES PEOPLE AVOID THEMSELVES OF HEALTH SERVICES WHETHER THEY CAN AFFORD THEM OR NOT.

114 ENCOURAGE WIDER AVAILABILITY OF LOW COST INS. W/ A SMALL CO-INS. FEE TO DISCOURAGE OVER-UTILIZATION. GOVT OR EMPLOYERS MIGHT HELP SUBSIDIZE THEN.

209 EXPAND INSURANCE PROGRAM IN SEVERAL WAYS

283 HAVE A MATCHING PROGRAM WHERE PREMIUMS FOR HLTH INS.ARE MATCHED BY FED/ST. GOVT FOR LOW INCOMES. ALSO EMPLOYER MATCHING. UNEMPLOYED SHOULD RECEIVE LESS BENEFITS RATHER THAN MORE.

419 I FAVOR SUBSIDIZING INSURANCE COSTS ON THE BASICS OF NEED WHICH MEANS THAT IT MAKES MORE SENSE TO ME FOR GOVERNMENT TO GIVE CREDITS TO LOW INCOME/LOW NET WORTH PEOPLE OF ANY AGE RATHER THAN GIVE BENEFITS TO PEOPLE JUST BECAUSE THEY ARE.

157 I THINK ITS A NAT'L PROBLEM. LOCALLY WE TREAT PEOPLE & WRITE OFF CHARGES AS NEEDED. IT'S THE WORKING POOR THAT HAVE THE MOST PROBLEMS & THE PEOPLE WHO ARE EXCLUDED FROM INSURANCE--DIABETES.

368 I'D LEGISLATE INSURANCE WITH NO RIGHT OF INSURANCE COMPANY TO REFUSE APPLICANT OR PERHAPS AN OUTSIDE UNDERWRITING PANEL TO WEIGH REFUSALS AND ALLOT STATE SUPPLEMENT TO THE PRIVATE INSURANCE COMPANY FOR ACCEPTING APPLICATION INSTANTLY.

127 MAKE HLTH CARE INS.THROUGH PRIVATE SOURCE AVAILABLE FOR EVERYONE NOT COVERED BY MEDICAID AND MEDICARE....THEN WEED OUT THE CONTINUED WASTE IN MEDICAID/MEDICARE PROGRAMS.

44 MANDATE DEDUCTIONS FROM WAGES TO PAY FOR EITHER EMPLOYER SPONSORED OR FEDERALLY SPONSORED HLTH INSURANCE.

264 MORE AFFORDABLE HLTH INSURANCE.

400 PAY FOR PREVENTIVE MEDICINE, CATASTROPHIC COVERAGE, OFFICE CALLS - TO INCREASING VISITS.

18 PRIVATE COMPANY SYSTEM SUPPORTED BY GRANT DOLLARS & MEDICARE/MEDICAID PMT. THIS WOULD BE A BASIS COVERAGE POLICY WITH NO "FRILLS". IF PT EMPLOYED, TAX FREE IRA TO FUND PRIVATE INSURANCE NEEDS MAY BE OF INTEREST OR EMPLOYER INCENTIVE TO INSURE EMPLOYEE

502 PROVIDE CATASTROPHIC HEALTH INSURANCE, BUT ON OTHER CLAIMS, REQUIRE CO-PAYMENT FOR SERVICES.

406 REQUIRE INSURANCE COMPANIES TO JUSTIFY EXTRAVAGANT PREMIUM COSTS. (PROOF OF INSURABILITY).

348 SBA SPONSORED GROUP HEALTH PLANS FOR SMALL EMPLOYERS. FICA TYPE WITHHOLDING MANDATORY FOR EMPLOYERS REFUSING TO OFFER HEALTH REDUCED BENEFITS.

129 STATE RUN POOL FOR UNDERINSURED WITH TAX, INSURER AND BUSINESS CONTRIBUTIONS.

288 SUBSIDIZE BLUE CROSS/BLUE SHIELD FOR THE WORKING POOR AND SIMILAR GROUPS OF PEOPLE.

43 USE A PERCENTAGE OF EACH SALARY.

432 USE VOUCHER SYSTEM BASED ON 150-200% OF POVERTY LEVEL INCOME TO UTILIZE EXISTING PRIVATE INS CO STRUCTURES. ADD A DEDUCTIBLE OR COPAY MANDATORY NO MATTER HOW SMALL TO KEEP PTS RESP. INVEST. RESOURCES.

341 WHEN THESE PEOPLE NEEDED MEDICAL CARE THEN SOMEHOW APPLY TO A PROGRAM TO LOOK AT THEIR NEED AND INSURE THEM.

339 WORK WITH PRIVATE INSURERS (COMPETITION) FOR A BASIC PLAN THAT WOULD BE AFFORDABLE.

74 1)SUBSIDIZE ST AS PRIVATE INSURANCE FOR WORKING POOR-BASIC BENEFITS.2)EXPAND MEDICAID 3)INCENTIVES FOR EMPLOYEES-INSURANCE.

424 REGULATE INS COMP & PHARM COMP & KEEP THEM FROM INCREASING THEIR PRICES. DECREASE GOVT INVOLVEMENT IN MEDICAL FIELD. ITS BECOMING MORE COSTLY BECAUSE GOVT AGENCIES ARE INCREASING IN SIZE & COSTING MORE MONEY. PTS COMPLAIN ABOUT MEDICATION COSTS MORE.

450 ELIMINATE ALL INSURANCE COMPANIES FROM HEALTH CARE. EXPAND MEDICARE OR SIMILAR PROG TO EVERY CITIZEN. EXPAND SOC. SECURITY METHOD TO COVER COSTS OF NATIONAL PROG. MAKE PT & LAWYER RESPON FOR COSTS OF LITIGATION WHEN PROVIDER IS CLEAR OF BLAME.

342 FORCE HEALTH INSURANCE INTO THE MONTHLY BUDGET WHENEVER POSSIBLE. PROVIDE PUBLIC CLINICS ONLY FOR THE UNEMPLOYABLE.

490 ENCOURAGE BUSINESSES TO COME TO MT TO INCREASE PAYROLL LABOR FORCE. SHIFT EXPENDITURE FROM WORKMAN'S COMP TO UNDERINSURED PROGRAMS. EDUCATE/PREVENTIVE MEDICINE: TOBACCO, ALCOHOL, COMMUNICABLE DISEASES.

160 1)REQUIRE ALL EMPLOYEES TO PROVIDE HLTH CARE INS.TO EVEN PART TIME EMPLOYEES 2)EXPAND HLTH EDUC. & MAINTENANCE COVERAGE FOR OUTPTS BY NURSES 3)DESIGN A MORE UNIFORM PROGRAM OF ALL PEOPLE CO-ADMINISTERED BY PRIVATE HLTH INSURANCE(MT MED.ASSOC. & GOVT).

369 HOSPITALS & PHYSICIANS PUBLICLY CONFESS THEIR CO-DEPENDENCE ON INFLATED INS. CHARGES. EDUCATE PUBLIC. ESTABLISH A FORM OF NATIONAL HEALTH INS. WITH LIMITS & UNAVOIDING RATIONING. REWARD HEALTHY LIFESTYLES.

418 MAKE LOW COST, BASIC COVERAGE AVAILABLE. RATIONING OR LIMITS WOULD BE NECESSARY.

265 1)CATASTROPHIC HLTH CARE COVERAGE FROM ST./FED.WITH A LARGE DEDUCTIBLE OF $500-1000. 2)ABILITY TO WRITE OFF OR GET CREDIT FOR BAD DEBT OR INCENTIVES TO ALLOW PROVIDERS TO "WANT" TO TAKE FINANCIALLY INDIGENT PTS.

124 DEFINE WHAT % ARE UNDERINSURED BECAUSE OF FAILURES IN PVT INS.SYSTEMS(WILL NOT COVER THOSE WHO NEED CARE, INAPPROPRIATE WAITING PER.)LOOK AT TAX INCENTIVES FOR SMALL BUSINESS. POOL FOR THOSE CHANGING JOBS AND ON UNEMPLOYMENT.

<u>LIABILITY/TORT REFORM</u>

260 1)PASS MEDICAL LIABILITY TORT REFORMS. 2)DON'T PENALIZE PHYS.FOR SEEING UNINSURED BY INC. LIAB. EXPENSE, INC. LIAB. EXPENSE,INC.BUREAU.HASSLES, OR FAIL TO COVER EXPENSES 3) TREAT CHARITY PTS W/OUT EXPECTATION THAT ALL CAN POSSIBLY BE MANAGED EQUALLY @ EXPENSE OF FEW.

52 I THINK GOVERNMENT AND LAWYERS SHOULD GET OUT OF MEDICINE. YOU GUYS ARE MISSING THE POINT.IN 5 YRS, YOU'LL BE LUCKY TO FIND A DOCTOR TO TAKE CARE OF YOU.WHAT DIFFERENCE DOES INS.MAKE IF ALL THE DOCTORS HAVE LEFT THE STATE.

97 I WOULD LIMIT LIABILITY CLAIMS FOR MEDICAL CASES TO 100,000 PAIN/SUFFERING. NO COMPENSATION FOR VACCINE REACTIONS.

433 PROVIDE FOR CLINIC SPACE FOR THE UNINSURED TO BE SEEN ON ROUTINE BASIS. STUDIES HAVE DEMONSTRATED THAT THOSE SEEN ROUTINELY REQUIRE LESS HOSPITALIZATION, HIGH EXPENSE CARE. SHOULD BE ADMINISTERED ON A COUNTY BASIS. (SPACE, TIME COMMITMENTS, ETC.)

449 ESTABLISH PROTECTION FOR HEALTH CARE DELIVERERS SO THEY WON'T GET SUED THEREBY LOWER COSTS SIGNIFICANTLY FOR EVERYONE. PRIORITIZE PEOPLE WHO ARE NOT COVERED IN TERMS OF HOW SICK THEY ARE. INCREASE ELIG. FOR MEDICARE & MEDICAID.

343 ADDRESS LIABILITY ISSUE. INCENTIVES TO EMPLOYEES TO PROVIDE ADEQUATE PRIVATE INSURANCE. INCENTIVES TO PROVIDERS TO PROVIDE REDUCED FEE SERVICES. TO COMPLEX AN ISSUE TO ADDRESS FURTHER IN THIS LIMITED SPACE.

210 MAKE CHANGES EG TORT REFORMS, TAX BENEFITS, OTHER INCENTIVES TO ENCOURAGE EXISTING PROVIDERS TO PROVIDE CARE AT REDUCED(OR AT TIMES FREE).

<u>NATIONAL HEALTH INSURANCE</u>

223 SOME SORT OF NAT'L HTLH INS.IS GOING TO BE NECESSARY. I'D LIKE OR SEE ONE W/AN EMPHASIS ON FAIR REIMBURSEMENT FOR PRIMARY CARE & INCENTIVES FOR PHYS.PRACTICE IN RURAL & MEDICALLY UNDERINSURED AREAS. I THINK THIS SHOULD BE PRIVATELY ADMINISTERED.

40 A NATIONAL HLTH INSURANCE PROGRAM ON A SIMILAR PROGRAM RUN BY PRIVATE ENTERPRISE WITH TAX DOLLARS FOR ITS SUPPORT. THIS WOULD BE BASED ON THE CANADIAN HLTH INSURANCE PLAN AND WOULD BE AVAILABLE TO EVERYONE.

325 BASIC HEALTH CARE PACKAGE FOR EVERYONE WITH ADDED BENEFITS FOR ADDED COST.

82 COPY THE CANADIAN/ALBERTA SYSTEM.

326 DESIGN A BASIC PROGRAM COVERING ESSENTIALS AS WELL AS COST EFFECTIVE SERVICES. INSURE THAT THE SAME PROGRAM IS OFFERED WITHOUT THE RESTRICTION OF GOVERNMENT INTERVENTION - INCLUDING TAXES -STATE, FEDERAL, AND LOCAL.

464 EITHER TO TWO TIER SYSTEM WITH STATE OR GOVT OR NATIONAL HEALTH CARE.

360 I DON'T REALLY KNOW. I THINK WE NEED A NATIONAL HEALTH CARE PROGRAM LIKE CANADA HAS.

197 IMPLEMENT NATIONAL HLTH CARE INSURANCE IMMEDIATELY.

48 INVESTIGATE ALBERTA'S HEALTH PLAN-SEE HOW WE MAY ADAPT.

323 IT IS IMPERATIVE WE DEVELOP SOME TYPE OF UNINSURED HEALTH CARE FOR ALL. IT IS TRAGIC THAT FAMILIES MUST STAY ON WELFARE IN ORDER TO OBTAIN SOME TYPE OF MEDICAL COVERAGE.

257 LOOK TO THE CANADIAN SYSTEM NO GOVT ADMINISTRATION.

430 MAKE SURE IT WAS DESIGNED BY BUSINESSMEN & HEALTH CARE PROVIDERS TO INSURE QUALITY. KEEP IT OUT OF THE DEMOCRATS HANDS. MAKE SURE IT MET THE BUSINESS STANDARDS OF ANY SMALL RUN COMPANY.

371 MANDATE A MINIMUM LEVEL HEALTH INSURANCE FOR ALL EMPLOYED PERSONS.

436 MANDATORY COVERAGE OF ALL THROUGH SOCIALIZED MEDICINE. STRICTLY ENFORCED FEE SCHEDULE FOR HOSPITALS AND PHYSICIANS SUPERVISED BY FEDERAL GOV.

50 MT WHERE SO MANY CITIZENS EARN LOW HOURLY WAGE-AT SMALL BUS.WHERE NO MED.CARE INS.-NO AVAIL.INCOME TO PURCHASE MED.CARE INS. OR PAY MED.COSTS-THERE NEEDS TO BE SOME FED.OR ST. PROGRAM TO TAKE CARE OF THIS GROWING PROBLEM.

307 NATIONAL COVERAGE FOR ALL.

453 NATIONAL HEALTH CARE SYSTEM.

501 NATIONAL HEALTH INSURANCE (CANADIAN).

31 NATIONAL HEALTH INSURANCE EXACT SYSTEM IS A PROBLEM BUT EVERYONE SHOULD HAVE ACCESS TO CARE WITHOUT RUNNING THE RISK OF BANKRUPTCY.

235 NATIONAL HLTH INSURANCE.

27 NATIONAL, UNIVERSAL HLTH INSURANCE.

414 NO PROGRAM WILL WORK UNLESS ACCESS IS AVAILABLE IN EQUAL FASHION FOR ALL. RICH/POOR, RURAL/URBAN. THIS WILL ENTAIL A NATIONAL EFFORT. WE NEED TO BE CERTAIN ANY SUCH PROGRAM GIVES EQUAL ALLOWANCES FOR MT/WYO RURAL PROB. & ALLOW FOR OUR UNIQUE REGION.

81 SOCIETY NOT MEDICINE SHOULD BEAR THIS EXPENSE. UNIVERSAL HEALTH CARE IS A RIGHT OF ALL AMERICANS.

281 SPONSOR A FEDERALLY FUNDED UNIVERSAL COMPREHENSIVE SINGLE PAYOR APPROACH SIMILAR TO CANADIAN.

258 STATE FUNDING FOR A PRIMARY PHYS.FOR EACH PERSON- PATIENT COULD CHOSE PRIMARY MD & SWITCH PERIODICALLY IF HE WISHED.

35 THE PIECEMEAL APPROACH IS INEFFICIENT & INCREASES ADMIN.COSTS. WE NEED A NTL HLTH CARE PLAN. IF MT INSTITUTES UNIVERSAL HLTH CARE, WHERE WOULD THE $ COME FROM? TAXES IN MT ARE HIGH ENOUGH COMPARED TO OTHER STATES.

456 UNIVERSAL COVERAGE & ACCESS TO HEALTH CARE. STATE RUN PROG MAY BE BEST WITH FEDERAL FUNDING INVOLVED. THIS IS A VERY COMPLICATED ISSUE. REDUCE OVERHEAD IN PRIVATE INSURANCE.

122 UNIVERSAL HLTH CARE, BASED ON A CAPITATION SYSTEM OR FEE-FOR-SERVICE SYSTEM (BILLED TO A CENTRAL AGENCY). BASED ON GENERAL PRIMARY CARE PHYS.ACTING AS NEEDED TO REFER PTS TO SPECIALISTS. LESS REIMBURSEMENTS FOR PROCEDURES, MORE FOR COGNITIVE SERVICES.

299 UNIVERSAL INS.ACCESS, DECREASE IN HI PRICE PROCEDURES/COMPENSATION (SURGEONS, CARDIOLOGISTS) CARDIO-SURGEONS ARE OVERPAID.

374 TRY TO DECREASE ADMINISTRATIVE COSTS -WHY NOT MEDICAID CARDS THAT ARE ISSUED EVERY 2-3 MONTHS RATHER THAN MONTHLY. WE NEED A UNIVERSAL HEALTH PLAN SO ALL MEMBERS OF SOCIETY CAN BE COVERED.

302 UNIVERSALLY HLTH CARE-UNIFORM-IE.NO MEDICAID,MEDICARE, NO IHS,NO TRIBAL-SIMPLE ACROSS THE BOARD UNIFORM ACCESS TO HLTH CARE.

384 CREATE UNIVERSAL INSURANCE WITH MANDATORY HEALTH PREVENTATIVE MEDICINE CLASSES FOR STATE ASSISTANCE WITH PREMIUMS. MANDATE GREATLY EXPANDED HEALTH EDUCATION IN GRADE & HIGH SCHOOL.

204 1)NEED MANDATORY HLTH INS.SYS.,PRIVATELY OR EMPLOYER FUNDED. 2)CUT/LIMIT HLTH CARE COSTS-DECREASE EXORBITANT SURGICAL/SPECIALIST REIMBURSEMENT & INCREASE FOR PRIMARY CARE MD.

333 FEDERALLY FUNDED, PRIVATELY MANAGED INSURANCE FOR UNEMPLOYED. ADEQUATE INSURANCE FOR EMPLOYED THROUGH EMPLOYER WITH PROPER INCENTIVES FOR SMALL BUSINESSES.

72 PRIVATE-FEDERALLY FUNDED UNIVERSAL HLTH INSURANCE VENTURE, CATEGORIES SIMILAR TO #11, WITH JOINT VENTURE BY PRIVATE INSURANCE TO EXPAND COVERAGE IN RETURN FOR CERTAIN INCENTIVES.

266 USE ST./FED.MONIES FOR FREE HLTH CARE. EXPAND & PROVIDE INCENTIVES FOR CURRENT PRIVATE INSURANCE COMPANIES TO ALLOW WIDER ACCESS TO THEIR PROGRAMS.

336 ENCOURAGE MANDATORY CO-PAYMENT TO AVOID OVER UTILIZATION. CONSIDER A SLIDING SCALE OF COST BASED ON INCOME. MAKE EDUCATION PROGRAMS MANDATORY FOR SMOKERS, DIABETICS. CONSIDER FEDERAL,STATE,OR PRIVATELY ADMINISTERED PROGRAM ALL CITIZENS PAY INTO FUND.

16 1)FED. MANDATED, PRIVATELY ADMINISTERED COMPREHENSIVE HLTH INS.W/ SUPPLEMENT FROM GOVT FOR THOSE UNABLE TO PAY.2)ELIMINATION OF CONTINGENCY FEES FOR LAWYERS IN MALPRACTICE AND CAP ON AWARDS 3)CAP ON MD FEES BRINGING "SURGICAL" IN LINE W/"MEDICAL"FEES.

115 TOTALLY REDO ENTIRE WAY MEDICAL CARE IS PAID FOR BY MAKING BASIC CARE PLAN AVAILABLE TO EVERYONE W/LIMITS FOR WHAT IS COVERED.(NO HEART TRANSPLANTS OVER 80 YRS LIKE OREGON IS TRYING TO DEFINE.)BUILD INCENTIVES INTO SYS.TO TAKE CARE OF SELF.

454 ACCESS TO HEALTH CARE SYSTEM IS ESSENTIAL FOR ALL GROUPS. DIVISION OF RESPON CAN BE ASSIGNED. CARE GIVERS MUST BE COMPENSATED & ALL SHOULD BE ENCOURAGED TO PARTICIPATE VOLUNTARILY. DISTRIBUTION SHOULD BE EQUAL FOR ALL HEALTH CARE TO ALL PEOPLE.

109 ESTABLISH A BASIC SERVICE NATIONAL HLTH INSURANCE-FEDERALLY FUNDED FROM TAX INCREASE TO COVER ALL CITIZENS, BUT NOT TO PRECLUDE THE ESTABLISHMENT OF PRIVATE HLTH INSURANCE FOR THOSE WHO CAN AFFORD OR DESIRE CONTINUED "AMERICAN" MEDICINE.

184 NATIONAL HEALTH CARE INSURANCE -TAX BASED FINANCING.

244 NATIONAL HLTH INSURANCE FOR UNEMPLOYED. REQUIRE OTHER HLTH INSURANCE FOR EMPLOYED W/ TAX BREAKS FOR EMPLOYERS OR TAX DEDUCTIBLE PREMIUMS FOR OWN HLTH INSURANCE.

276 OFFER A COMPREHENSIVE, TAX FUNDED, PRIVATELY RUN PLAN THAT WOULD INCLUDE ALL PEOPLE. PRIVATE INSURANCE SHOULD BE GIVEN TAX INCENTIVE AND CREDIT IF IT EQUALS OR EXCEEDS THE TAX FUNDED PLAN.

218 MANDATE ST/FED.GOVT TO SUPPLY HLTH INS.TO ALL PTS.-ADD TO INCOME TAX A FEE FOR HLTH INS.EQUALLY SHARED BY ALL PEOPLE(EVERYONE PAYS A FEE) PROVIDE MEDICAL LIAB.INS.ASSISTANCE TO ALL MD'S WHO PARTICIPATE IN MEDICAID. EMPHASIS ON PREVENTATIVE CARE. #217

261 1)FED.HLTH CARE PROGRAM AGE 0-18. 2)TAKE FLAT % OF INCOME AS TAX AGE 18 & UP. 3)EXPAND HLTH DEPT.TO INCLUDE THOSE WHO CAN'T PAY-USING GATEKEEPER IDEA 4)USE WELFARE TECHNIQUES EMPLOYED BY LDS CHURCH.

ENCOURAGE PATIENT RESPONSIBILITY

212 ANY ADULT ON MEDICAID(W/CHILDREN)SHOULD HAVE TO WORK GIVEN # OF HRS. A WEEK. THERE'S PLENTY THEY COULD DO(WORK ON ROADS, ELDERLY). ABLE BODIED PEOPLE SHOULD NOT BE ON MEDICAID.

426 ARRANGE FOR UNDERINSURED TO WORK FOR THEIR BENEFITS - WHETHER IT BE PLANTING TREES OR PICKING UP GARBAGE. YOU VALUE THINGS FOR WHICH YOU WORK. PERSONS WHO DO NOT PAY FOR HEALTH CARE HAVE A LOW REGARD FOR THAT WHICH THEY RECEIVE.

472 ASSIST LOW INCOME PERSONS, OR FAMILIES IN PAYING FOR THEIR MEDICAL CARE WITHOUT THEIR HAVING TO BE TOTALLY ON WELFARE.

404 BASE CARE ON NEED NOT AGE. DO NOT SUPPLEMENT CARE FOR THOSE WHO CAN AFFORD MEDICAL COSTS. EVEN MOST MEDICARE PATIENTS DON'T REALIZE THAT PHYSICIANS ARE MANDATED TO CHARGE THEM LESS THAN THE GOING RATE. OTHERS ARE FORCED TO PAY HIGHER DUE TO MEDICARE.

483 ENCOURAGE RECIPIENTS TO FOLLOW MEDICAL ADVICE FOR HEALTH CARE BY MAKING BENEFITS REVOKABLE. ALSO PROVIDE FOR REVOCATION IF BENEFITS ABUSED THRU OVERUSE OF VISITATION RIGHTS. RECAPTURE ANY BENEFITS OBTAINED FOR TREATMENT IN PERSONAL INJURY IF AWARDED.

328 EVERYONE SHOULD PAY SOMETHING INTO A SYSTEM BASED ON INCOME BUT SOMETHING.

499 HELP TO HELPLESS BUT QUIT MAKING DEPENDENT PEOPLE OUT OF THOSE WHO ARE NOT HELPLESS.

130 I WOULD PROVIDE HLTH CAR-CATASTROPHIC COVERAGE ONLY & RE-INSTITUTE THE OLD FEE-FOR-SERVICE & PRIDE OF PAYING ONE'S OWN WAY.

489 I WOULD START BY TAKING THE FEAR AWAY FROM MEDICAID RECIPIENTS. MOST WON'T ACCEPT A BETTER PAYING JOB IN FEAR THEY'LL LOSE THEIR ASSISTANCE. IT KEEPS THEM DEPENDENT IN PUBLIC ASSISTANCE.

467 INCREASE TAX ON CIGARETTES & ALCOHOL. USE REVENUE TO PROVIDE SERVICES.

376 INCREASE TAX ON TOBACCO, ALCOHOL & GASOLINE. MONEY TO BE USED FOR EDUCATION. CO-PAYMENT REQUIRED FROM ALL PATIENTS DECIDED BY ABILITY TO PAY. EXCEPTION PRENATAL & WELL BABY CARE SHOULD BE AT NO CHARGE.

298 IT APPEARS WHEN INDIVIDUALS DON'T HAVE TO PAY FOR SOMETHING IT LOSES VALUE. THESE PEOPLE TEND TO BURDEN THE SYS.W/ UNNECESSARY TRIPS TO ER OR DR OFFICE VISITS. GIVE THEM SOME SORT OF INCENTIVE NOT TO RUN TO MED.CARE EACH TIME THEY HAVE SLIGHTEST PROB.

102 REQUIRE $10,000-25,000 ESCROW ACCOUNT FOR USE IN CARE OF ACCIDENT VICTIMS TO BE PROVIDED BY ALL PURCHASERS OF MOTORCYCLES IN THIS STATE.

175 SET UP LEGALITY & OPERATIONAL PLAN TO PUT PERSONS TO WORK IN COMMUNITIES THEY LIVE IN AS "PMT" FOR SERVICES THEY NOW GET (FOOD STAMPS, MEDICAID, ETC.)GEARED TO ABILITIES TO RESTORE SELF ESTEEM & HELP RID THE GRUDGING ATT.FROM BURDENED TAXPAYERS OF MT.

471 TAX ON CIGARETTES, ALCOHOL, AND FINES FOR NON USE OF SEATBELTS TO PROVIDE MEDICAL CARE. SALES TAX ALSO TO FUND. EXPAND MEDICAID. INCLUDE MORE PATIENT RESPONSIBILITY (CO-PAYMENT TO REDUCE UNNEEDED USE).

304 TAX TOBACCO & USE PROCEEDS MATCHING FEDERAL DOLLARS TO PROVIDE HEALTH CARE TO PREGNANT WOMAN AND CHILDREN.

407 THEY SHOULD PAY SOMETHING TO PRESERVE THEIR DIGNITY AND TO REINFORCE APPRECIATION.

435 TIGHT CONTROL OF WHO QUALIFIES; WITH ADHERENCE TO CONDITIONS SUCH AS NO SMOKING AND DISQUALIFICATION FOR OBESITY, ETC.

457 WE CAN'T AFFORD ANY SOLUTION! AT LEAST NOT ONE THAT IS ADEQUATE. PERHAPS SOME OF THE RECIPIENTS WOULD DO SOME WORK.

389 WHATEVER THE INSURANCE PLAN THERE MUST BE PARTICIPATION BY THE RECIPIENT, ON A SLIDING FEE SCHEDULE TO PAY A PORTION; OTHERWISE THE PATIENT FEELS THERE IS NO VALUE TO THE CARE & THAT ALL DOCTORS ARE EQUAL IN THEIR BACKGROUND OF KNOWLEDGE.

142 PROVIDE IN NUMEROUS LOCALS, ST.FUNDED CHILD CARE & ST.RUN WORK PROJECTS WHERE MEDICAID RECIPIENTS & UNDERINSURED WOULD HAVE TO PARTICIPATE IN ORDER TO RECEIVE FOOD STAMPS,ADC, & MEDICAL INS.IN ADDITION TO WAGES. KEEP SOME AWAY FROM ALCOHOL/TOBACCO.

334 STATE DESIGNATES QUALIFIED INSURANCE POLICIES. SLIDING SCALE - RICH PAY ALL, POOR PAY NONE. PLANS ADMINISTERED PRIVATELY IF POSSIBLE.

125 ANY PROGRAM MUST HAVE TIGHT CONTROLS TO PREVENT ABUSE AND OVER UTILIZATION AND SHOULD INCLUDE TORT REFORM RE LIABILITY ISSUES.

111 ELIMINATE ABUSE OF SYSTEM BY ST./FED. ASSISTANCE RECIPIENTS. THIS HAS BEEN SUCCESSFUL IN MANY AREAS W/OUT SERIOUS DRAWBACKS. 2)TORT REFORM & INCENTIVE PROGRAMS FOR PROVIDERS TO SEE "NEEDY" UN OR UNDERINSURED AT REDUCED RATES.

203 PAY AS MUCH AS YOU CAN ON SLIDING SCALE(INCOME TAX)-NOTHING FREE-MARKEDLY REDUCE TOTAL COSTS & REDUCTION OF 1)EQUIPMENT ALLOWED 2)ELIMINATION OF ALL BUT ACT.DAMAGES FOR MALPRACTICE. 3)CHANGE ATTITUDE OF DEFENSIVE MD. NO CONTINGENCY FEES FOR LAWYERS.

211 1)NEED MOTIVATOR TO STAY HEALTHY 2)NOT ABUSE THE BENEFITS OF THE PROGRAM. 3)EQUAL ACCESS FOR ALL PTS.

181 SALARIED MD'S TO PROVIDE CARE W/ LIMITS ON AVAIL.DRUGS, LAB, & EXTENT OF TREATMENT FOR SELF LIMITED ILLNESS & LIMITS ON COMPLEX CATASTROPHIC CARE (OREGON PLAN). FREE CARE & INCENTIVES FOR WOMEN TO OBTAIN BIRTH CONTROL & SUR.STERIL. ENCOURAGE ABORTION.

327 COVER PREVENTATIVE SERVICES. TAX CREDITS FOR STOPPING TOBACCO AND ALCOHOL OR PREMIUM.

<u>RATIONING</u>

358 DEBATE IN PUBLIC FORUM WHAT IS THE MINIMAL LEVEL OF HEALTH CARE THE PEOPLE OF THIS COUNTRY NEED/WANT, THEN DETERMINE WHAT THIS MINIMAL LEVEL WILL COST, & THEN TAX ALL OF US TO PAY THIS COST.

291 EVALUATE CURRENT AMT SPENT IN TAXES & INS.PREMIUMS. PROFITS & MANPOWER COSTS MIGHT BE SUFFICIENT TO COVER 30% UN/UNDERINSURED. I WOULD THEN REDUCE FUNDING FOR EXOTIC TECH.& TRANSPLANTS THAT COST SO MUCH & HELP SO FEW.

413 LIMIT BENEFITS EXPENDED FOR THE AGED WHO NOW USE THE GREATEST PERCENTAGE OF MEDICAL DOLLAR AND DIVERT IT TO THE YOUTHS.

485 NOTED PREVIOUSLY - THE GOLDEN POT MUST BE ELIMINATED FOR HIGH TECH. 90% OF THE MONEY PAYS FOR 10% OF THE PEOPLE.

479 SEE 9. PRIORITIZING HEALTH CARE EXPENDITURES IS URGENT RE PRENATAL CARE. CASE MANAGEMENT AND COORDINATION IS IMPORTANT. ALL CITIZENS SHOULD HAVE ADEQUATE HEALTH CARE COVERAGE.

193 SHIFT FUNDING AWAY FROM EXPENSIVE HIGH TECH PROCEDURES (ESPECIALLY FOR ELDERLY PATIENTS), SUCH AS OPEN HEART SURGERY, HEAR/LUNG TRANSPLANTS, ETC.

119 WATCH EVOLUTION/DEVELOPMENT OF OREGON PROGRAM CLOSELY-IF IT SURVIVES. TRY TO EDUCATE ALL CITIZENS AND MEDICAL PEOPLE THAT RATIONING OF SOME SORT IS ESSENTIAL. FAIR IS NOT SYNONYMOUS WITH EGALITARIAN.

13 FEDERALLY FUNDED PROGRAM WITH LIMITS ON TRANSPLANTS, DIALYSIS, BYPASS SURGERY AND OTHER EXPENSIVE PROCEDURES MORE FUNDING FOR BASIC, PREVENTIVE SERVICES.

TAX INCENTIVES

501 ALLOW DOCTORS TO TREAT PATIENTS AND DEDUCT FROM THEIR INCOME TAX (FEDERAL AND STATE).

95 EMPLOYER TAX CREDITS FOR EMPLOYEE INSURANCE. MINIMUM COVERAGE OF UNEMPLOYED BY EXPANDING MEDICAID.

5 ESTABLISH A SYSTEM WHEREBY PROVIDERS COULD RECEIVE TAX ADJUSTMENTS FOR PROVIDING FREE SERVICES (UNCOMPENSATED SERVICES) TO THE NEEDY.

427 GIVE INCENTIVES TO MD'S TO CARE FOR UNDERINSURED AT REDUCED FEE'S - IE MAKE WRITE OFFS TAX DEDUCTIBLE.

98 GIVE PEOPLE AND PROVIDERS INCENTIVES-BUT AVOID GIVEAWAY PROGRAMS AND TAX INCREASES.

219 I WOULD GIVE TAX CREDITS TO PHYS.EQUAL TO THE AMT OF THE UNPAID BILLS OF THESE PTS. THAT WOULD INSURE NEARLY 100% PARTICIPATION OF PHYS.IN CARING FOR THESE PATIENTS.

256 INCENTIVES FOR SELF FUNDED HEALTH INSURANCE AND EMPLOYER BASED PLANS. STATE FUNDED UNINSURED POOL.

225 IT WOULD BE NICE IF THERE WERE SOME INCENTIVES TO TREAT UNDERINSURED THROUGH THE STATE HELPING IN MALPRACTICE INSURANCE AND OTHER FIXED COSTS.

238 MANDATE HTLH CARE COVERAGE. BENEFITS FOR EMPLOYER WHO PROVIDES PREVENTATIVE SERVICES. EXPAND LOW ACUITY TREATMENT. AVOID "CRISIS ONLY" MEDICAL AVAILABILITY.

498 OFFER SOME TAX INCENTIVE TO CARRY OWN INSURANCE. OFFER INSURANCE FOR CATASTROPHIC ILLNESS. OFFER INSURANCE FOR MAJOR ILLNESS.

45 OFFER TAX INCENTIVES & OTHER INCENTIVES FOR PRIVATE INSURANCE COVERAGE.

278 OFFER TAX INCENTIVES TO PHYS.WHO PROVIDE SUCH CARE.

71 PAYROLL TAX COMMENSURATE WITH PAYROLL THAT EACH EMPLOYER WOULD CONTRIBUTE TO-TO PURCHASE PRIVATELY ADMINISTERED INSURANCE-ADMINISTER BY A STATE EMP.

496 PROVIDE ADEQUATE PROVIDER REIMBURSEMENT TO ENHANCE WILLINGNESS TO PROVIDE CARE. SCREEN FOR PATIENT NEED FOR SUCH CARE & ENCOURAGE EMPLOYMENT IF EMPLOYABLE. GET INTO MDHES PROGRAMS.

309 PROVIDE INCENTIVES FOR EMPLOYERS TO HAVE EMPLOYEE MEDICAL COVERAGE.

104 PROVIDE INCENTIVES TO EMPLOYERS TO COVER EMPLOYEES AND DEPENDENTS.

196 PROVIDE INCOME TAX REBATES TO PHYSICIANS WHO PROVIDE CARE TO MEDICAID/MEDICARE PATIENTS.

170 REIMBURSEMENT TO PROVIDERS MUST BE ADEQUATE TO IMPROVE ACCESS TO CARE.

226 SALES OR INCOME TAX TO PROVIDE PUBLIC HEALTH CLINICS AND HOSPITALS FOR ALL THOSE UNWILLING OR UNABLE TO PAY FOR PRIVATE CARE.

370 SINCE COMPUTERIZATION & UTILIZATION & REVIEW DATA CAN QUANTIFY MOST ANYTHING ALLOW DEDUCTION OF FEDERAL & STATE INCOME TAX DEDUCTION OF CARE DELIVERED SIMILAR TO CHARITABLE DEDUCTION.

186 1)GET EMPLOYEES TO HELP BY TAX INCENTIVES FOR HLTH INS. 2)INDIVIDUALS W/ INS.CAN DEDUCT (TAX INCENTIVES) 3)INCREASE MEDICAID PAYMENTS AND EXPAND ELIGIBILITY.

452 ATTEMPT TO CONTROL MEDICAL COSTS. ALLOW TAX SAVINGS AS INCENTIVE. PLAN UNIVERSAL COVERAGE. START SOME DEGREE OF RATIONING. CONTROL COSTS BY LIMITING DUPLICATION OF EXPENSIVE EQUIP. FORCING MD'S TO FILL OUT ENDLESS FORMS ADDS TO THE COSTS-STOP HASSLE.

8 SEE#9 RESULTS: 1)FREE CARE FOR POOR 2)ELIMINATE MEDICAID BUREAUCRACY 3)MDS HAVE FINANCIAL INCENTIVE TO PROVIDE CARE AS WELL.

94 FULL COMPENSATION FOR PROVIDERS OF INDIGENT CARE. INCREASE SUPPORT FOR FREE STANDING INDIGENT CARE FACILITIES. INCENTIVES OR SUPPLEMENTAL PMT/GROUP INS.PLANS TO PROMOTE PRIVATE INS.AMONG WORKING POOR.

477 OF GREAT HELP WOULD BE VARIOUS FACTORS WHICH WOULD DECREASE HEALTH CARE COSTS SUCH AS TAX REFORM & LIMITS ON LIABILITY EXPOSURE FOR THOSE PROVIDING CARE FOR THOSE WITH LITTLE OR NO INS COVERAGE. TAX INCENTIVES FOR PROVIDING UNCOMPENSATED CARE.

123 PROVIDE INCENTIVES TO PHYS.TO SUPPLY CARE-REMOVE LEGAL LIABILITY FOR MEDICAL CARE MANY OF THESE PTS ARE LITIGIOUS & SEEK OUT LAWYERS BEFORE DOCTORS. ALSO WOULD ALLOW MD DECISION ON TESTS ORDERED & LIMIT # OF TESTS DONE TO PROTECT LIABILITY.

359 GIVE PEOPLE INCENTIVES. PATIENTS NEED TO HAVE INCENTIVES TO CARE FOR THEMSELVES & NOT TO ABUSE THEIR PRIVILEGES TO MEDICAL CARE. DOCTORS & HOSPITALS NEED TO FEEL GOOD ABOUT HELPING PEOPLE. WHY SHOULD SOCIETY HELP THOSE WHO WON'T HELP THEMSELVES?

56 PROVIDE INCENTIVES (FINAN.)TO PHYS.FOR PROVIDING CARE TO THE UN OR UNDERINSURED.IF WE ALL HAD AN OPEN DOOR POLICY, THE RISK WOULD BE SPREAD AROUND AT THE RISK OF STEREOTYPING.MANY LOW INCOME, POORLY EDUCATED PTS TAKE ADVANTAGE OF THE SYSTEM.SURVEY#56

338 TAX BENEFITS FOR UNCOMPENSATED CARE. WORK REQUIREMENTS FOR ABLE-BODIED RECIPIENTS. INCENTIVES FOR EMPLOYER-BASED INSURANCE. TORT REFORM. PREVENTION OF OVER UTILIZATION OF SERVICES BY THOSE NOT PAYING FOR THEIR CARE.

OTHER COMMENTS

25 1)ASSESS MAGNITUDE OF PROBLEMS 2)EVALUATE RESOURCES 3)DETERMINE WAYS TO HAVE (2) AND SOLVE (1).

301 1)ASSESS WHICH POP. IN MT ARE MOST W/OUT HLTH CARE. 2)EXAMINE RESOURCES-WHAT PROGRAMS/PROVIDERS ARE AVAIL. TO MEET NEEDS 3)PLAN USING AVAILABLE RESOURCES-STEPS TO EST.NEW RESOURCES 4)IMPLEMENT PLAN THEN EVALUATE BASED ON HLTH STATUS OF POP.

282 1)ORGANIZATION #9 2)CHARGE COUNCIL WITH DEVELOPING SHORT TERM ANSWERS AND LONG TERM PLAN FOR CHANGES IN HLTH CARE SYS. 3)ST MONEY TO ACQUIRE UP-TO-DATE FACTS 4)PROVIDE FROM ST AGEN.PERTINENT MT STATS 5)SET DATES FOR PRELIMINARY REPORT W/RECOMMENDATION.

248 ACCESS AMERICA PLAN BY AMA IS APPROPRIATE FOR THE TIMES.

317 BE VERY IDEALISTIC AND HAVE A HUGE BUDGET.

231 CONDUCT A STUDY AS I NOTED UNDER #9, THEN DESIGN A PROGRAM.

230 CURRENTLY TRYING TO DEVELOP PROGRAM TO PROVIDE GREATER ACCESS TO QUALITY CARE FOR MEDICALLY INDIGENT & MEDICAID PATS HERE IN MSLA. LOCAL PHYS.REFUSING TO CARE FOR POP. & ANNOUNCEMENT OF THE UPCOMING CLOSURE OF THE MEDICAL CLINIC.

202 DENTAL HYGIENIST FOR EVERY COMMUNITY.

329 DEVELOP A STATE WIDE GROUP DEDICATED TO THE PROBLEM AND START A PILOT PROGRAM.

DON'T KNOW - 9 RESPONSES.

150 EMPHASIZE CARE FOR PREGNANCY, INFANCY, AND CHILDHOOD BECAUSE THESE ARE AREAS OF GREATEST SOCIAL IMPACT.

475 EXERCISE MANY OPTIONS AS OF SECTION 10. SO MUCH DEPENDS ON INDIVIDUAL, FAMILY AND CHANGING STATUS AND LOCATION.

331 EXPAND MEDICAID.

38 GET A JOB.

451 GO NUTS.

321 HEALTH CARE SHOULD NOT BE VIEWED AS AN ECONOMIC DRAG ON THE SYSTEM BUT RATHER IT SHOULD BE VIEWED AS A MAJOR SERVICE PROVIDER INDUSTRY. IT PROVIDES MANY JOBS. HEALTH CARE SHOULD BE CONSIDERED A VALUABLE PART OF THE GNP. IT IS A BOOM NOT A PROBLEM.

273 I WILL BE SENDING A LETTER OUTLINING MY IDEAS. BUT BEFORE YOU CAN DESIGN A PROGRAM YOU HAVE TO KNOW & UNDERSTAND WHY SO MANY PEOPLE ARE UNINSURED-ONCE IT IS UNDERSTOOD-THEN A PROGRAM CAN BE DESIGNED. THANKS.

19 IN THE COUPLE OF MINUTES I HAVE TO COMPLETE THIS SURVEY IT IS IMPOSSIBLE TO REACH A CONCLUSION ON THIS QUESTION. IT IS A PROBLEM THAT NEEDS CONSIDERABLE THOUGHT BY FEDERAL, STATE, AND MEDICAL AUTHORITIES.

438 ITS HOPELESS UNTIL THE NATIONAL MORALITY RESUMES PROPER PRIORITIES.

350 KEEP IT SIMPLE.

158 LOOK AT AMERICAN ACADEMY OF PEDIATRICS ACCESS TO CARE PROPOSAL.

417 NOTE I RETIRED IN JUNE 1982. THE PROGRAMS CHECKED ARE THE ONES I WAS SOMEWHAT FAMILIAR WITH DURING MY PRACTICE YEARS.

344 PAY THE PROVIDERS ADEQUATELY AND STOP TAKING FROM ONE MOUTH TO FEED THE OTHER ONE. EVERY YEAR GOVERNMENT CUTS BACK PROVIDER PAYMENTS MORE AND MORE. WHAT DO YOU WANT US TO DO WORK FOR FREE.

392 PROVIDE CARE FOR OUR CHILDREN. THE FUTURE OF OUR STATE AND NATION DEPENDS ON THEM.

444 PROVIDE JOBS WITH ADEQUATE INSURANCE COMPARABLE TO THE BLUES.

300 PROVIDE MULTI-TIERED SYS.OF BASIC EMERG.CARE/HOSPITAL CARE PROVIDED BY PARAMEDICAL & MD-PRIORITIES CLEARLY ESTABLISHED-FUND W/ST/FED.TAXES-DECR.MILITARY SPEND. EACH IND.CONTRIBUTE ON ABILITY TO PAY. INC.COST TO HI RISK BEHAVIORS. ALL MD'S BE INVOLVED.

354 PROVIDE STATE SUBSIDY OR FEDERAL SUBSIDY TO GET THEM COMPLETE COVERAGE.

64 PUNT. THE PROBLEM AS I SEE IT IS $ FORM THE LEGISLATURE, WHICH LACKS $ FOR ALL THE WORTHWHILE PROPOSALS IT FACES.

445 PUSH EDUCATIONAL PROPAGANDA OF PUBLIC HEALTH NATURE: BOOZE, NICOTINE, IMMUNIZATIONS, CHILD CARE(PRE-NATAL & POST-NATAL), RESPONSIBILITY FOR SELF.

96 PUT THEM BACK TO WORK.

272 READ THE ENCLOSED MATERIAL FORM AMA. WE DO NOT HAVE HLTH CARE PLANNING-IT'S A JUMBLE.

191 REDUCE MEDICAL CHARGES.

447 REQUIRE INSURANCE WITH ALL JOBS.

284 RESTRUCTURE THE AMA INTO A GROUP CAPABLE OF AND MOTIVATED TO WORK IN THESE FIELDS.

365 SEE 10. I HAVE SPENT A SIGNIFICANT AMOUNT OF TIME ON THIS AT A NATIONAL LEVEL AND FEEL WE DO NEED A CHANGE. WOULD BE VERY HAPPY TO DISCUSS MY VIEWS MORE EXTENSIVELY.

361 SEE 9. MEDICINE HAS TO STOP BEING A PROFIT ORIENTED BUSINESS WITH INCENTIVES TO DO MORE PROCEDURES.

377 SEE PRIOR PAGE. WE CAN'T DELAY LONGER. WE ARE SACRIFICING OUR CHILDREN'S FUTURE WITH OUR INDECISION.

126 START BY CHANGING THE PHYSICIANS GREEDY ATTITUDES AND DISREGARD FOR ANYTHING BUT $.

267 START OVER.

163 STATE OR SOME GROUP TO PAY THE PREMIUMS OF THE ONES WHO ARE UNABLE TO PAY.

337 TOO MANY PROBLEMS WITH A STATE OPERATED PROGRAM WHERE THE STATE WAS A PROVIDER. UTILIZATION ABUSE IS THE MAJOR FLAW IN ANY PROGRAM FOR PARTIAL OR TOTALLY SUBSIDIZED CARE.

478 WITHHOLD PORTION OF PAY TO BE MATCHED BY STATE OR FEDERAL FUNDS TO GUARANTEE BASIC COVERAGE FOR UNINSURED.

293 1)BETTER MEDICAID FUNDING FOR OB CARE-REIMBUR.RATES FOR MEDICAID NOW BARELY COVER OVERHEAD & NOT AN INCENTIVE TO TAKE MORE THAN YOUR SHARE OF INDIGENT OB PTS WHO ARE HI RISK FOR PROBLEMS, MORE TIME NECESSARY IN CARE AND LIABILITY.

APPENDIX V

December 28, 1990

Marjorie Levine
Culbertson Hall, Room 308
Montana State University
Bozeman, MT 59717

Dear Ms. Levine:

I received a letter from you asking for input into the access to health care in Montana. I did receive your letter but not a copy of the survey. I will, however, give you some of my ideas about ways to increase access to people who really need it.

1. Eliminate unlimited health care to people who have never put anything into the system. Everyone who uses health care should pay something for it, and I think that should be more than $1.00. Most of these people have money for cigarettes and booze, and so they should have some money for health care.

2. Decrease malpractice costs. There are a number of lawyers in this state who ~~used to~~ use the legal system to obtain out of ~~state~~ court settlements. Insurance companies are very reluctant to litigate when they can settle for less than $15,000. It is cheaper for them to settle out of court than it is to litigate. Most lawyers will pursue litigation until settlement is obtained whether they have a reasonable case or not. I think that there should be something in the Montana law which would make the attorneys and attorney's client responsible for court costs and loss of income to physicians and expenses of the insurance company to litigate these matters if they lose their cases. This would cut down a lot on the number of litigations against physicians and would allow insurance companies to decrease their malpractice insurance. It would also allow us not to order tests that we think are nonessential to patients health care that are now being order to protect most of us in the health care profession.

3. Another way to cut expenses, from our end, would be to make the billing system easier. Medicare is a nightmare to get a payment from them and is, at best, a nightmare. The bureaucracy is so huge, and I suspect that most of their budget is not spent in paying for medical care but in maintaining their own positions and maintaining the huge bureaucracy in place to run Medicare. I think that if the billing system was made easier

that huge and vast amounts of money could be saved not only on the taxpayers part but also in physicians business offices. All of these things would decrease the payments for medical care and would allow medical health insurance companies to decrease their premiums allowing more people to be able to afford to buy it.

Montana Health Professions Education Foundation, Inc.
308 Culbertson Hall
Bozeman, MT 59715

Dear Sirs:

Enclosed is your recent questionnaire, which was supposed to be returned by Dec. 1. I apologize for being late, but this problem is so important that I gave it a lot of thought, and hence this letter, since you invited comments.

The whole tenor of your questionnaire seems to indicate the favorability of more government interference in health care. It seems that government interference is one of the chief causes of the financial difficulties we have in medical care. The incredible rules and regualtions that have been foisted on us by medicare and medicaid make it considerably more expensive to practice medicine, and now private insurance companies are following suit with their regulations. All of this requires more expensive secretarial help so that the doctor can practice medicine. The same applies to hospitals

The second problem which increases expense is the malpractice situation. In Montana the malpractice panel is very useful in cutting down the number of lawsuits, but insurance is still very expensive. The insurance costs involve not only doctors and hospitals, but also medical supply and drug companies. How else can it be justified to cost $5000 for the hardware for total hip prosthetics or an increase in price of 20 times for pertussis vaccine? The attitude of the courts seems to be that something went wrong, therefore someone must pay, even though it was an "act of God." God cannot be sued, so man is sued. Of course judges should throw many of these cases out of court, but then the judges would be sued!

The third financial problem in health care is the proliferation of expensive technology, and the almost limitless costs of protecting and improving human life. There is much overuse of various tests, and our doctors are not taught in medical school or in postgraduate training to be selective in the tests they order. They should be so instructed. For instance, it is not necessary to have a CT scan of the head for every headache that comes in, yet I have seen this done.

And lastly, there is the problem of price inflation, which can be laid almost entirely at the door of the Federal Government, with no end in sight. Since Medicare was instituted there has been a price inflation of approximately 10-15 times. Doctors charges have just about kept even with this inflation, but hospital charges have now far exceeded inflation, largely because of new

and very expensive technology.

The above summarizes the causes of the financial crisis in health care. Now, what do we do about it? First of all, increasing government involvement will not make it any cheaper. It will only lead to more rationing of care, with waiting lines for non-emergency care, such as a two year wait in England or Canada for a total hip or knee operation, whereas in the U.S. one can have it next week. The demand for health care is infinite, the means to pay for it are not. Therefore there must be and always has been some kind of planned or unplanned rationing. Government financed and planned care will not help the situation, it will only make it worse. It has never worked well in other nations, why should it work in the U.S., or in Montana. Cadillac quality health care will never be available for all citizens until these same citizens can pay for it themselves.

I have no ultimate solution to the problem, but a start can be made. First, the malpractice situation must be alleviated. When I began practice my insurance was $250 per year. Were I still in practice, it would cost now about $40,000, without any change in the way I practice! Second,costs can be alleviated somewhat by training health care professionals to be more selective in the tests they order. No one needs a sonogram, plus a CT scan plus an NMR imaging , but I know of this being done. When all else fails, do a history and physical! Third, stopping government devaluation of the currency through inflating would be a great help, but does not seem to be in the cards at present. Fourth, take care of the patient first, ask about his or her ability to pay later. This has worked for centuries, why not now?

Increased government intervention and financing will do nothing except make the situation worse.

Robert J. Flaherty, M.D. &
Marjorie C. Levine, M.S., R.D.
Montana Health Education Center
Montana State University
Culbertson Hall, Room 308
Bozeman, MT 59717

Dear Doctor Flaherty & Ms. Levine:

It is difficult to know where to begin to address some of issues raised in your questionnaire. I am 58 years old and have practiced medicine in Montana since 1961, and so also practiced pre and post Medicare. One of my objections prior to Medicare and Medicaid as we know it now is that there actually were people (particularly the elderly) who would go without medical care if they didn't have the funds to do it. Thus, one of the blessings of Medicare was treatment for these people.

Interestingly, there has been some change over the years. With Medicare, the patient is responsible for payment in part for themselves, so people still tend to think about it before they use the system. I don't see nearly as much Medicare abuse as I do Medicaid.

In reference to question 5, "What priority should the following groups be given for federal and state health care assistance programs", it is really hard to assign a priority. Small business employees probably have problems because they don't get paid well, probably because their employers can't often afford the extra cost. It may interest you to know that one of my good friends who owned a newspaper took home less income each year than his typesetter because the typesetter belonged to a union. The editor was required to pay the typesetter a generous wage and because he owned a small paper he wasn't able to make much himself. Therefore, for him to provide medical insurance for his employees would really have been a hardship. Certainly that is an area that needs to be investigated. It may be that migrant workers should be covered under a federal program rather than state. Obviously, anyone that is poor has to be considered. A minority person would not need special assistance if that minority person were very successful and financially self sufficient. Though again generalizations are difficult and I'm not sure my answers really meet your needs.

In regard to question 7, working people who earn a small income but who try to pay their bills tend to delay seeking medical attention. Indigents who are used to the Medicaid system would never let that bother them at all. The same would be true of the other comments in that particular question except for "f". I think adopting healthy lifestyles and following good preventive measures is more related to education, which would then ordinarily mean that a patient is more likely to be economically self sufficient. Many of the patients I see that are unable to pay are people who often don't think ahead or have never been educated to make such provisions. Interestingly enough, my Medicaid patients are more likely to be heavy smokers. Smoking is an expensive habit and I often wonder where they find the money for cigarettes and yet are not able to pay for necessities in life and are on government assistance.

Question 8 - How frequently did I do the following because I knew the patient was unable to pay? Over my lifetime, a sick patient that needs help is always going to get the time needed. As indicated in my comments, I do not believe in making people do unnecessary follow-up appointments. I do not like to overuse x-ray or lab and, where possible, I am always mindful (no matter who the patient is) to use less expensive medication, if it's effective. Whereas I always try to give the patient the care and time they need, I would be less than honest if I didn't feel some resentment against some patients. I have seen Medicaid patients in the emergency room for care at 11-12:00 p.m. because they didn't wish to sit in the office and wait or because that seemed to be the convenient time for them. I have one young lady who has never seen me in the office but rather arrives in the emergency room around 11:00 p.m. where the cost is at least three times of what it would be in my office during the day. People who smoke two packs of cigarettes a day but can't afford to see that their kids get medication and people that in other ways abuse the system and cause an increase in everybody's expenses and taxes naturally raise my hackles. I have tried educating the same people in getting things done in a better manner, yet they come back with the same old problem. In these cases, I sometimes do get short and have trouble being kind.

I certainly feel the Medicaid system in this state is in many cases abused. I have many patients who are on Medicaid that use it intelligently, but as mentioned above, many of them run to the emergency room at all hours resulting in costs that are three times what they normally should be because of the time that they choose to come for care. They tend to resort to stop-gap measures rather than preventive medicine, and they never seem to plan ahead. Some means of making these people responsible for

some part of their care might act to stem the tide a little bit. I also believe that some sort of penality should be placed on patients that use the system in a very expensive way and tend to be repeaters who abuse the system. This in itself would help control Medicaid costs.

The other problem of the Medicaid system is that like any assistance system, it tends to be all or nothing. I have had mothers who tell me they would like to get off assistance. However, they get paid well enough on assistance and any job they would get would never be able to carry them in the same manner. If a person is willing to accept a job that doesn't pay them too well, then I think the government should pay the difference between what that person earned and what they would make if they were on an assistance program. This would get people back in the job market and I think eventually help get them off assistance programs. I think the people most likely to be denied access to health care are those who are just well enough off to not qualify for Medicaid, are to proud to ask for help and don't have the finances to buy medical insurance. They probably fit into the category of a lower middle class. Some way needs to be found to help them. I'm sure I don't have a good answer of how to accomplish that though.

As to designing a program to improve health care of the underinsured, I would probably have to participate in some conference where one would be able to discuss these issues for a couple of days. I really don't feel I'm grounded to give good advice in that area.

Finally, I think one of the biggest dangers in a state such as Montana and many other rural areas is the loss of the family doctor. With the malpractice situation as it is and with the vast changes in technology, we are killing off the people in the rural areas who would like to practice medicine there. The other thing, believe it or not, is some doctors can't make a living in the rural areas. Overhead in our office is about 60 percent. Medicaid and Medicare are two of the poorest payers and what they pay doesn't begin to cover overhead in a medical office. Since family doctors don't do a lot of technological procedures, they aren't able to bill for and meet the increased costs that occur in taking care of Medicare/Medicaid patients. Also, in many areas of the state, this is primarily what these doctors have to deal with. Therefore, it becomes a vicious circle and a losing battle.

Much lip service is paid to the importance of giving patients time. However, nobody wants to pay for time, they only want to pay for technology. After 12 years of postgraduate education and

with the expenses of running a medical office on a per hour basis, I earn less per hour than an engineer on the railroad who can go to work as an engineer straight out of high school. I don't begrudge the engineer what he or she makes but you are going to find it hard to get people to come out of a 12 year education with lots of debts and have them willing to move into a situation where they work long hours with no adequate compensation. Doctors have never had a large share of the health care dollar, at least from any figures that I have seen. One of the ways to increase access for people to medical care would be to see that family doctors in rural areas are paid very, very well. It would be somewhat in the neighborhood of what some of the specialists earn and then expect them to take all comers.

I may have rambled on but I hope it is of some use to you. Enclosed you will find a note from one of our employees to us doctors regarding our uncollected bills. As you can see, Medicaid is the biggest culprit. This represents a large amount of our past dues.

If you have any questions, don't hesitate to contact me.

ATB Totals	98,222
Medicare/Medicaid	24,769
Railroad Medicare	756
Medicaid	63,981
Medicare	8,716

Over 180 Days	70,295
Medicare/Medicaid	18,552
Railroad Medicare	0
Medicaid	47,674
Medicare	4,068

121-180 Days	2,780
Medicare/Medicaid	1,188
Railroad Medicare	0
Medicaid	1,361
Medicare	231

91-120 Days	5,135
Medicare/Medicaid	820
Railroad Medicare	137
Medicaid	4,068
Medicare	110

61-90 Days	2,517
Medicare/Medicaid	571
Railroad Medicare	99
Medicaid	1,634
Medicare	213

31-60 Days	6,072
Medicare/Medicaid	793
Railroad Medicare	120
Medicaid	3,847
Medicare	1,312

0-30 Days	11,424
Medicare/Medicaid	2,845
Railroad Medicare	401
Medicaid	5,396
Medicare	2,782

December 4, 1990

The Montana Area Health Education Center
308 Culbertson Hall
Montana State University
Bozeman, MT 59717

Dear Sir:

I have been a little slow answering this questionnaire because it's the hardest one I have ever seen. I think the way that some of the questions are designed is going to make it difficult for you to get answers which are meaningful so I am going to shine mine up a bit with the narrative that follows.

In question #5, I think people who are trying to help themselves deserve more help than those who don't. Certainly people who move here from other states to benefit from some of our relatively generous programs are bothersome to me. People who are unable to help themselves through problems which are no fault of their own also should be given high priority. I don't think that age, minority status, citizen status, what specific occupation or some of your other categories are relevant at all in this question.

In question #6, we do not accept assignment on most Medicare patients anymore so we only get about 5% of our collections directly from Medicare but about 30% of our work is Medicare and we get this reimbursement indirectly from the patients.

In question #7, it is difficult for the physician to answer because we don't really know how much medical care is averted by people who feel that they will do without rather than to incur debts they can't pay.

Question #9 of course is vexing to people with greater knowledge and intellect than we will ever have and so it would be presumptuous for any of us to try to answer it. Nonetheless I will make a brief stab at it. Surely some kind of rationing of health care is essential. I would like to put a good connotation on the term "rationing". I would use the term to mean dividing a relatively scarce resource so that everyone gets as much as he needs. It is inevitable there will be some consolidation of our delivery systems. There will be

fewer larger insurance companies and other third party payers. It is going to be necessary to rely somewhat more heavily on primary care and put relatively more rationing on high technology medical work. In Montana it is going to be necessary to raise a bit more money in taxes to pay for the health care of those who can't pay for their own. These are more in the neighborhood of predictions and facts than they are recommendations I suppose.

In question #10, I suppose all the ideas both good and back that I've heard lately are listed there. Certainly Montana is not going to administer health insurance for all citizens, it's totally out of the question. The Federal Government could probably do that, and ultimately it might. To expand eligibility and services covered by Medicaid doesn't help the physician much since reimbursement usually is less than overhead cost. In fact it might decrease the availability of services to do that. At the present time I see a relatively small number of Medicaid patients and I can do this relatively cheerfully. But if a much larger percentage of patients out there were covered with Medicaid I would probably not see any of them. The other ideas listed are complex.

Number #11, most of these programs are tremendously beneficial to the patients who receive them. Often they are not so very beneficial to the physicians or hospitals who provide services or to tax payers who pay for them and in some cases they are not especially beneficial to physicians who have to compete with these programs while paying a healthy overhead.

Number #12 is just too hard for me.

January 4, 1991

Majorie C. Levine, N.S.,R.D.
Program Coordinator, MT AHEC
Montana Health Education Center
Culbertson Hall Room 308
Montana State University
Bozeman, Montana 59715-9928

Dear Ms Levine:

My late response to the survey "How Montana Physicians View Access to Health Care" has already been forwarded to you. Enclosed here is a report from the National Center for Policy Analysis, a think tank in Dallas, Texas: the report is entitled "An Agenda for Solving America's Health Care Crisis". The report, I believe, is excellent, well presented, and contains many ideas which could be enacted on the state level, as well as the federal. I hope you will find it informative reading. I have a great interest in these areas and would be happy to assist in any way I can, although any significant time commitments on my part will need to be postponed until after I pass my oral board exam this fall.

Thank you.

APPENDIX VI

COMMENTS

RESPONDENT #	
7	AVOID ADDING RESPONSIBILITIES TO EXISTING BUREAUCRACIES WHICH ARE INEFFICIENT, UNRESPONSIVE, ARROGANT AND NOT RELATIVE TO CAUSE-EFFECT RELATIONSHIPS OF THE REAL WORLD.
14	DON'T NEED FURTHER GOVT MANDATES ON HOW, WHEN, AND WHERE WE PRACTICE MEDICINE. LEGISLATION AS: MANDATORY MEDICARE ASSIGNMENT IS UNFAIR, SOCIALISTIC AND WILL PROB. DECREASE THE # OF COMPETENT MDS DESIRING TO PRACTICE MEDICINE IN MT.WE ARE PROFESSIONAL
15	AS IT IS NOW, THE PEOPLE WHO CARE ABOUT STAYING HEALTHY & WHO DON'T ABUSE, MEDICARE & MEDICAID & PUT INS.-ARE SUBSIDIZING ALL THE OTHERS-THIS IS WRONG & DOES NOT PROVIDE PROPER MOTIVATION.
21	HLTH CARE SYSTEM IS A MESS.COST IS DUE TO MEETING REGULATIONS IMPOSED TO ASSURE QUALITY, DOCUMENTING CARE FOR REIM.& MALPRAC.CONCERNS.SYSTEM IS BUILT ON A POOR FOUNDATION WHICH BANKRUPT ST.IF ATTEMPT TO PROVIDE HLTH COVERAGE.PAY AS GO/SALARIED CARE
23	SYSTEM WE HAVE DOESN'T WORK.LIMIT MD'S INCOME SO DON'T FEEL PRESSURE TO DO PROCEDURES TO MAKE $.LIMIT LIAB.UNLESS TRANSPLANTS,DIALYSIS EXOTIC TEST, HAVE RX FORMULARY SO THE COST OF MEDS GOES DOWN.LIMIT MEDICAID ACCESS SO DON'T ABUSE. LOOK AT SURVEY22
27	I FEEL VERY STRONGLY THAT ALL AMERICANS SHOULD HAVE EQUAL CARE AND ACCESS TO CARE. (I HAVE NEVER AGREED WITH THE MAJORITY OF PHYSICIANS ON THIS SUBJECT)
29	HOPE IT WORKS
30	MOST PEOPLE SPEND LESS MONEY FOR HLTH CARE THAN WHAT INSURANCE PREMIUMS COST. PERHAPS A PROGRAM TO HELP COVER EXPENSES OVER $2000-3000 ETC WOULD BE HELPFUL.
35	MORE RESPONSIBILITY FOR HLTH CARE COSTS SHOULD BE PLACED ON INDIVIDUALS WHO INDULGE IN HI RISK BEHAVIOR (SMOKING,DRINKING,ABUSING DRUGS,RIDING MOTORCYCLES,ETC.)
39	MEDICAID-TOO MUCH ABUSE OF THE SYSTEM MEDICARE-BUT NOT NECESSARY FOR ALL THOSE OVER 65. SEE SURVEY 39.
41	RESERVATIONS ON ANY SURVEYS

44 THE GREATEST IMPACT PROGRAM FOR REDUCING THE COST OF MEDICAL CARE WOULD BE SIGNIFICANT TORT REFORM. THIS WOULD REMOVE THE PARASITIC ELEMENT OF THE LEGAL PROFESSION THUS FREEING UP MILLIONS OF DOLLARS FOR HLTH CARE.

48 PHYSICIANS-HOSPITAL-LAB FEES ALL ARE OUTRAGEOUSLY TOO HIGH.

50 FOR YEARS I HAVE BELIEVED THAT PRIVATE MED.CARE WAS THE IDEAL FOR NATION,BUT IN THE FACE OF EXCESSIVE & CONTINUED RAISING MED.COSTS WE WILL END UP W/SOME TYPE OF NATIONAL HLTH PROGRAM SUCH AS IN CANADA OR ENGLAND.

56 ONE OF THE REASONS I LEFT MY MULTI-SPECIALTY GROUP & STARTED A PRIVATE PRACTICE IS THAT MY PARTNERS THOUGHT I WAS NO BRINGING IN ENOUGH (TOO MUCH CHARITY WORK). I WOULD BE HAPPY TO DISCUSS THIS FURTHER. AIMEE V.HACHIGIAN, M.D.

60 IMPROVE THE SMALL BUSINESS ENVIRONMENT BEFORE YOU TOUCH ON AUTOMATIC HLTH INSURANCE. I COULD WRITE A BOOK....IN FACT, I THINK I WILL

64 IN OUR AREA THERE ARE INSUFFICIENT NURSING HOME. THE LOCAL HOSPITAL IS FORCED TO EAT $ TO AN ALARMING NUMBER WAITING PLACEMENT OF MEDICARE PATIENTS-FOR WHOM NO $ IS FORTHCOMING LDRG'S?

66 MEDICAID'S IDEA IS GREAT BUT THESE PTS DO NOT HAVE THE RIGHT TO ABUSE THEMSELVES (TOBACCO) AT TAXPAYERS EXPENSE AND EXPECT TO BE TAKEN CARE OF WHEN THEY HAVE PROBLEMS.

75 THE SYSTEM CANNOT BE ALTERED TO PERFECTION. WE CANNOT AFFORD TO EXTEND CURRENT LEVELS OF CARE FOR EVERYONE. WE NEED A NEW SYSTEM ENTIRELY & ADEQUATE (NOT FANCY)CARE FOR LOW ECONOMIC LEVEL PEOPLE & ALLOW THOSE WHO WANT PRIVATE CARE TO HAVE IT.

76 ANY PROGRAM SHOULD EMPHASIZE INCREASED INDIVIDUAL INCENTIVE AND DECREASE USE OF TAX DOLLARS.

78 I HAVE MORE AND MORE DAYS WHEN I THINK THAT SOMETHING LIKE THE CANADIAN "MEDICARE" ISN'T SUCH A BAD IDEA-FOR PATIENTS AND DOCTORS. ENSURE ACCESS TO CARE, REDUCE THE HASSLE, GET PAID PREDICTABLY.

81 TIME IS RUNNING OUT.

86 IS HEALTH INSURANCE A RIGHT OF THE CITIZENS OR A MORAL OBLIGATION FOR THE STATE?

87 GOOD SURVEY-GOOD THOUGHT-CRITICAL ISSUE

90 PARAGRAPH 10 WITH FINANCIAL HELP FOR PREMIUMS FOR THOSE WHO NEED

94 QUESTION #12 CONT. PROMOTE INDIVIDUAL SAVINGS PLANS TO PROVIDE FOR ROUTINE HLTH CARE ALONG WITH INSURANCE COVERAGE FOR CATASTROPHIC ILLNESS OR HIGH EXPENSE HLTH CARE.

98 REGULATIONS ARE DRIVING US OUT OF BUSINESS. RURAL MT HOSPITALS ARE DYING. THAT WILL DEVASTATE RURAL LIVING, ECONOMIES, AND HLTH CARE ACCESS.

107 MY PTS ON MEDICAID GO TO ER FOR NONEMERGENT PROBLEMS TO SAVE $1. MT SHOULD PASS A LAW LIKE IN KANSAS THAT ENFORCE CO-PAYMENT OF $2 IN THE ER & ALLOW DRS TO REFUSE TO SEEM THEM IN ER FOR NONEMERGENT PROBLEMS. SEE SURVEY #107.

114 HOW FAR SHOULD WE GO IN TREATMENT OF THE INFANT WITH CONGENITAL DEFORMITY? ORGAN TRANSPLANTS? OPEN HEART SURGERY PAST AGE 90? PROLONGATION OF LIFE IN FATAL DISEASE? RECURRENT CANCER? AIDS?

120 INTERESTED IN RESULTS OF SURVEY. THANKS. SIOBHAM MCNALLY, M.D. ADDRESS ON SURVEY #120

124 I'M AFRAID THE SYSTEM IS FAILING BECAUSE OF TOO MANY OUTSIDE INFLUENCES AND DIFFUSION OF RESPONSIBILITY FOR CARE.

128 THANKS

132 MEDICARE IS A BUREAUCRATIC MASS THAT IS OVERLY COMPLICATED AND COMPLEX AND NOT PATIENT FRIENDLY.

138 OUR SYS.IS NOT A SYS. IT IS A PATCHWORK OF PROGRAMS, SOME OF THEM TOO POLITICAL (INDIAN HLTH SERVICE, VA). THE SYS.ULTIMATELY MUST BE BASED ON EQUITY AND JUSTICE NOT THE POLITICS OF ENTITLEMENT.

145 ALREADY HAPPENED IN BILLINGS, AND IS PLACING UNFAIR BURDENS UPON THOSE OF US THAT DO SEE MEDICAID. OTHER STATES HAVE NEARLY TWICE THE LEVEL OF REIMBUR.FOR PRENATAL CARE.

154 SURGICAL PRACTICE-A LOT OF QUESTIONS DON'T REALLY APPLY.

179 NOT COMPLETE SURVEY-NOT IN ACTIVE PRACTICE JESS T.SCHWIDDE, M.D. 1449 TETON AVE, BILLINGS, MT 59102

180 YOUR LETTER SAID THIS WOULD ONLY TAKE A FEW MINUTES-WRONG! THIS IS NOT A SIMPLE QUESTIONNAIRE.

203 AS CHIEF MEDICINE MAN WOULD GOOF UP YOUR STATS SO I DIDN'T COMPLETE. TOSS IT OUT. NORM

204 FAIRER COMPENSATION FOR COGNITIVE PRIMARY CARE SERVICES WILL INSURE THAT MD'S WILL GO INTO FAMILY PRACTICE AS A CAREER.

211 SOUNDS LIKE NATIONAL HEALTH POLICY IS OUR ONLY SOLUTION. NOW THE TASK IS GETTING PHYSICIANS INVOLVED IN THE PROCESS NOT LEAVING IT UP TO THE POLITICIANS.

212 I GET SICK OF MEDICAID PTS TELL ME THEY MOVED TO MT BECAUSE IT'S PRETTY HERE & WE CHECKED OUT THE WELFARE& CAN GET ALONG ON IT IN THIS ST. MOST OF MY MEDICAID PEOPLE ARE ABLE BODIED & WOULD NOT MOVE HERE IF MT WELFARE WERE NOT SO EASY TO OBTAIN.

218 I GET PAID $754 FOR DELIVERING A MEDICAID BABY-EACH BABY I DELIVER COSTS ME $390 IN EXTRA LIAB.INS.-I MAKE $364 ON EACH BABY-BY THE TIME I PAY FOR MY EXPENSES THERE'S NOTHING LEFT FOR ME. REALLY FAIR!

226 IT'S TIME TO SEPARATE PUBLIC FROM PRIVATE MEDICAL CARE. COST-SHIFTING HAS PASSED THE POINT OF NO RETURN AND PHYS.ARE PISSED OFF EN MASS.

230 I AM BECOMING INCREASINGLY PESSIMISTIC THAT WE WILL BE ABLE TO AFFORDABLY DEVELOP A SOLUTION FOR OUR LOCAL COMMUNITY SHORT OF A NAT'L SOLUTION. I AM EQUALLY DISCOURAGED AT THE LACK OF PRIMARY CARE & SUBSPECIALTY PHYS.SUPPORT AT OUR ATTEMPTS.

231 PEOPLE ARE BEING RIFTED BY MEDICAL CARE EVERY DAY. SOMEDAY MEDICARE WILL PAY A SEVERE PRICE FOR THIS UNLESS IT SETS THINGS RIGHT-NOW.

238 MORE FOCUS ON CHILDREN.

272 IT ALL TAKES MONEY. WE GET WHAT WE PAY FOR.

278 I BELIEVE ALL PHYS.SERVICES REQUIRED, WOULD BE PROVIDED IN RESPONSE TO ADEQUATE TAX INCENTIVES. THIS WOULD LEAVE ONLY THE COST OF MEDICAL SUPPLIES, MEDICINES, AND HOSPITAL EXPENSES, WHICH COULD BE AT LEAST PARTIALLY COVERED IN A SIMILAR FASHION.

281 I AM AN ACTIVE MEMBER OFF PHYS.FOR A NATIONAL HLTH PROGRAM. I HAVE A VOLUME OF MATERIALS TO SHARE WITH THE U OF M AND COMMITTEE FOR HUMANITIES WE ARE SPONSORING A SYMPOSIUM W/NATIONALLY RECOGNIZED SPEAKERS ON THE ISSUE OF HLTH CARE REFORM. PLEASE CONTACT ME FOR MORE INFORMATION: PAT HENNESSY 243 NORTH AVE E MISSOULA, MT 59801 (721-8849)

283 I'M TIRED OF THE WORKING POOR GETTING HIT BY THE COSTS WHILE MEDICAID PT WHO NEVER WORKS AND NEVER INTENDS TO WORK GETS BETTER QUALITY CARE. I HATE TO SAY IT BUT ITS TOO GOOD ON WELFARE NO ONE WANTS OFF.

284 IF THE AMA HAD 1/2 THE BALLS OF THE NRA WE WOULD STILL HAVE A PROFESSION.

290 TOO EASY TO GET ONTO MEDICAID IN THIS STATE. PEOPLE COME HERE FROM ELSEWHERE TO HAVE THEIR BABIES ON MEDICAID.

291 I WOULD PAY TEACHERS FOR TEACHING, NOT RESEARCH, AT LEAST UNTIL WE SORT OUT WHAT IS AFFORDABLE. TEACH & ENCOURAGE PREVENTIVE HLTH MEASURES & BUILD INCENTIVES INTO EMPLOYMENT. REMOVE THE LEGAL SWORD THAT FORCES DRS TO OVERUSE TESTING.

294 MANY MEDICARE PTS ARE FINANCIALLY ABLE TO MANAGE THEIR HLTH EXPENSES & THERE ARE THOSE THAT CAN'T. THERE SHOULD BE SOME SORT OF WAY OF SEPARATION OF THESE TWO GROUPS.

300 LET'S BEGIN NOW TO EDUCATE PEOPLE THAT "THERE IS NO SUCH THING AS A FREE LUNCH," THAT HEALTH CARE WILL BE RATIONED.

301 I HAVE ATTACHED A SHEET EXPLAINING RESPONSES TO QUESTION #10. SEE SURVEY #301.

302 IHS TRIBAL HLTH IS A SHAM AND MEDICAID OB IS GROSSLY UNDER-FUNDED.

305 MENTAL HTLH SERVICES FOR MEDICALLY INDIGENT HAVE FALLEN TO DANGEROUSLY LOW LEVEL. OFTEN NOT AVAILABLE OR NOT ACCESSIBLE. NEGATIVE IMPACT ON FAMILY.

313 PHYS.SHOULD NOT BE FORCED TO TAKE ASSIGNMENT ON MEDICARE PTS. WITH CURRENT OVERHEAD (A LOT OF IT PAPERWORK REQUIRED BY THE GOVT) A DOCTOR WHO TOOK ONLY MEDICAID AND ASSIGNED MEDICARE WOULD GO BROKE.

317 GOOD LUCK

323 STUDY THE CANADIANS AND IMPROVE ON IT FOR ALL.

326 IF SOCIETY IS TO MAKE HEALTH CARE A RIGHT UNDER THE CONSTITUTION IT MUST ALSO BE FREELY DELIVERED AND UNRESTRAINED - WITHOUT RESTRICTION OR RATIONING.

329 INEVITABLY, THERE WILL BE AN EXPANSION OF FEDERALLY OR STATE WIDE SUPPORT FOR HEALTH CARE AND THE SOONER MONTANA CAN CREATE AN ORGANIZATION DEDICATED TO PLANNING, THE BETTER.

330 WHAT WE REALLY NEED IS A NATIONWIDE NETWORK SO THAT WE CAN GET "INSTANT" RECORDS ON ANY PATIENT. I HAVE PROBABLY WASTED MILLIONS ON POOR PATIENTS BECAUSE I HAVE TO DO MEGA WORKUPS TO BE SURE I'M NOT MISSING SOMETHING.

331 MEDICAID WORKS. IT NEEDS EXPANSION TO COVER ALL THAT NEED IT AND ADEQUATE PAYMENT PROGRAM.

337 WE NEED TO GET PRIVATE INSURANCE TO MORE WORKING POOR, STUDENTS, ETC.

338 ADDED BUREAUCRACY IS NOT THE ANSWER.

342 FREE HEALTH CARE ENCOURAGES UNEMPLOYMENT JUST AS DOES ANY WELFARE PROGRAM. IT ALSO CREATES A DEMANDING POPULATION THAT IS NEARLY IMPOSSIBLE TO CARE FOR.

353 EXTREMELY TOUGH PROGRAM - GOOD LUCK!

357 THANK YOU.

358 THE SYSTEM CURRENTLY IS VERY COMPLICATED. WE NEED TO LOOK TO WAYS TO IMPROVE THE EFFICIENCY OF THE SYSTEM TO HOLD COSTS DOWN.

363 TOO MUCH WASTE IN SYSTEM. IF THOSE ON MEDICAID MONITORED TO AVOID ABUSE, EDUCATED TO TELL WHEN NEED MEDICAL CARE, CLINICS STAFFED WITH PA'S & NURSE PRACTITIONERS WITH REFERRAL TO MD'S WHEN NECESSARY THERE WOULD BE MORE FUNDS AVAILABLE TO SERVE OTHERS

365 DON'T LEGISLATE FOR COMPLETE & OBLIGATORY ACCEPTANCE OF ASSIGNMENT FOR MEDICARE - LET WEALTHY RECEIVE CARE AT A CUT RATE. THROUGH COST SHIFT WE ARE PAYING THEIR WAY. THIS NEEDS TO BE UNIFORMLY INSTITUTED, NOT HIT & MISS AT THE STATE LEVEL.

370 WE HAVE TO PROMOTE ALL HEALTH CARE PROVIDERS DONATING X AMOUNT OF TIME WHEN THAT AMOUNT EXCEEDS THEN CAN EQUAL CHARITABLE TAX DEDUCTION

374 WE NEED TO WORK ON THE TEENAGE PREGNANCY PROBLEM. THIS ADDS A GREAT COST TO OUR SOCIETY AS A WHOLE AND PERPETRATES PROBLEMS.

381 BETTER BEGINNINGS PROGRAM FOR OBSTETRICAL PATIENTS IS EXCELLENT. IF NOTHING ELSE IT PROVIDES A WAY FOR NON-MEDICAID INDIGENT PATIENTS TO GEN AN MD WITH MULTIPLE PHONE CALLS.

390 SMALLER HOSPITAL OR SMALLER COMMUNITY SHOULD NOT TRY TO COPY BIG CENTER WITH ALL OF THE EXPENSIVE, SELDOM USED EQUIPMENT.

393 WOULD LOVE 5 MINUTES TV TIME TO EXPRESS MY VIEWS. KICK DEAD BEATS OFF WELFARE. ABLE BODIED PERSONS - NO WORK/NO WELFARE. HANDICAPPED PERSONS - NO WORK/NO WELFARE.

407 MY PRAYERS ARE WITH YOUR EFFORTS.

408 IF MORE FUNDS WERE DEVOTED TO FAMILY PLANNING - LESS MONEY WOULD BE NEEDED FOR INDIGENT CHILD CARE.

413 THIS IS NOT A VERY GOOD QUESTIONNAIRE.

416 WE NEED INCREASED ACCESS TO TITLE X - FAMILY PLANNING PROGRAMS AND MEDICAID FUNDING ON 1ST TRIMESTER ABORTION.

418 EXCELLENT SURVEY OF AN AREA OF CRITICAL NEED.

419 I THINK ITS BEST TO MAKE ANY RECIPIENT PAY SOMETHING FOR ANY HELP THEY RECEIVE SO THAT THEY KNOW THAT NO MATTER HOW MEDICAL CARE IS FINANCED IT IS VERY EXPENSIVE AND SHOULD BE USED APPROPRIATELY.

423 I WISH I HAD MORE CONSTRUCTIVE SOLUTIONS TO OFFER.

425 CONSIDERABLE EXPANSION OF THE NATIONAL HEALTH SERVICE CORPS PROGRAM OR MANDATORY SERVICE FOR ALL MEDICAL SCHOOL GRADUATES IN UNDERSERVED ARES WOULD HELP.

427 MONTANA MEDICAL/LEGAL PANEL IS VITAL TO RURAL PHYSICIANS PROVIDING HEALTH CARE. IT REDUCES THE VERY REAL THREAT OF MERITLESS LAWSUITS.

428 WE ARE NOW A SOCIAL DEMOCRACY. EVERY SOCIAL DEMOCRACY IN RECORDED HISTORY HAS COLLAPSED UNDER FISCAL POLICIES & GONE THRU ANARCHY INTO SOME FORM OF DICTATORSHIP. RETURN TO CHRISTIAN CONSTITUTIONAL REPUBLIC & LET CHRISTIAN CHARITY PROVIDE FOR NEEDY.

430 I BELIEVE THE FED GOVT TO SOME EXTENT WILL DESTROY THE US MEDICAL SYSTEM AS WE KNOW IT IN THE NEXT 5-15 YRS. OF COURSE INSURANCE WILL STILL EXIST SO WE'LL HAVE 2 TIER SYSTEM THAT WILL RESEMBLE ENGLAND. UNFORTUNATELY WE AREN'T LEARNING FROM THEM.

432 THE SYSTEM MUST NOT MAKE 2ND CLASS CITIZENS OF OUR NEEDY PATIENTS (AS DOES MEDICAID) NOT DENY HELP TO THOSE IN NEED.

436 CURRENT MEDICAL CARE DELIVERY SYSTEM TOTALLY INADEQUATE BECAUSE OF EXORBITANT HOSPITAL AND PHYSICIAN FEES.

438 GOOD LUCK!

446 ABOUT TIME SOMEBODY STARTED THIS PROCESS. THANKS FOR GETTING IT UNDERWAY.

447 MEDICAID & MEDICARE PATIENTS ARE UNDERINSURED. PRESENT DRG POSITION AS TO TIME LIMITS FOR PSYCHIATRIC CARE IS USE A VIABLE SYSTEM.

453 IF YOU NEED ANY HELP ORGANIZING AND FOLLOWING THROUGH, GIVE ME A CALL JOSEPHY F. KNAPP, JR., M.D. - 406-721-5600.

455 BENEFITS MUST BE TIED TO REQUIREMENTS THAT PATIENTS PARTICIPATE IN THEIR OWN HEALTH CARE.

456 LEGISLATORS NEXT FALL 1991 WILL BE DEALING WITH MANY PROPOSALS & REFORMS OF HEALTH CARE. I HAVE TO BE IN WA D.C. IN MAX BAUCUS'S OFFICE FOR 2 MONTHS NEXT FALL TO HELP HIS STAFF WITH UNDECIDED ISSUES.

458 WHY NOT TRY PILOT TEST PROGRAMS IN SEVERAL CLINICS THROUGHOUT THE STATE.

463 HEALTH CARE IN THE US WILL NOT BENEFIT FROM MORE GOVT INVOLVEMENT. IT WILL ONLY GET WORSE AS WE HAVE SEEN OVER THE YEARS SINCE 1965.

465 WAY TO MUCH BUREAUCRACY IN OUR STATE & FEDERAL PROGRAMS - FUNDS OF LARGE % USED FOR ADMINISTRATION OF PROGRAMS WHICH IS NOT THE INTENT OF THE LAW.

472 I THINK THAT IF WE HAD SOME TYPE OF NATIONAL OR STATE HEALTH INSURANCE, THAT MORE PEOPLE WOULD SEEK CARE FOR COMMON PROBLEMS WHICH WOULD KEEP GP'S BUSIER & POSSIBLY MAKE THIS A MORE ATTRACTIVE SPECIALTY AS WELL AS RENDERING CARE TO MORE PEOPLE.

475 WHEN ILLNESS STRIKES USE THE OCCASION TO ASSESS INDIVIDUAL AND FAMILY NEEDS AND FIT INTO OPTIONS AVAILABLE.

479 WE CAN NO LONGER AFFORD DISCOORDINATED & DISORGANIZED SYSTEM OF HEALTH CARE DELIVERY. WE HAVE LIMITED RESOURCES. WE WASTE MONEY ON NEWBORNS & ELDERLY, AT THE EXPENSE OF CHILDREN, YOUTH, & ADULT WORKING SEGMENTS OF OUR POPULATION.

486 HAVE NO SPECIFIC RECOMMENDATIONS BUT BELIEVE THAT INCENTIVE PROGRAMS IE. PROGRAMS THAT WILL AFFORD THE INITIATORS SAME RETURN AN THEIR TIME & INVESTMENT.

489 THERE IS A LOT OF PAID BY OUR TAXES BUREAUCRACY. WHY CAN'T SOMEONE COME UP WITH THE RIGHT SOLUTION TO THIS PROBLEM? THE PROBLEM LAYS IN THE FACT THAT PUBLIC ASSISTANCE & MEDICAID IS GIVEN TOO FREELY & IS GIVEN TO EASILY. LET THESE PEOPLE WORK.

498 AVOID SOCIALIZED PLANS THAT COVER EVERYONE. ENCOURAGE SELF RESPONSIBILITY THROUGH EDUCATION SO THAT TOBACCO, ALCOHOL-DRUG INDUCED ILLNESS IS LESSENED.

501 REVAMP THE LOCAL CARE OF PSYCHOTIC PATIENTS, AND SEVERE MENTALLY ILL TO BE SENT DIRECTLY TO WARM SPRINGS.

506 HELP US ("PROVIDERS AND CONSUMERS," DOCTORS AND PATIENTS). THE PRESENT NON-SYSTEM IS AWFUL.

520 LIMIT PROFITS OF DRUG AND EQUIPMENT SELLERS. PREVENT DRUG COMPANIES FROM DIFFERENTIAL PRICING TO CANADA AND MEXICO.

524 BECAUSE THE STATE AND FEDERAL GOVERNMENT WILL NEVER BE ABLE TO PAY THE "GOING RATE" FOR MEDICAL SERVICES AND ARE NOW PAYING LESS AND LESS, AND BECAUSE OUR FED./STATE GOVERNMENTS ARE BROKE, THE LOGICAL ANSWER IS TO GIVE SOME INCENTIVE TO HEALTH CARE PROVIDERS TO SEE THE UNDERINSURED, ETC. THOSE INCENTIVES COULD BE TORT REFORM, PAPERWORK REDUCTION, TAX INCENTIVES.